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REPORT

OF THE

Committee on Inquiry into the Departments of Health, Charities, and Bellevue and Allied Hospitals

IN THE CITY OF NEW YORK

APPOINTED BY THE

Board of Estimate and Apportionment

GEORGE McANENY, CHAIRMAN
President of the Borough of Manhattan
GEORGE CROMWELL
President of the Borough of Richmond
} *Committee*

INVESTIGATION AND REPORT UNDER THE DIRECTION OF

HENRY C. WRIGHT

CITY OF NEW YORK

1913

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Section I.—INTRODUCTIONS AND SUMMARIES

1. Letter of Transmittal
2. Introduction by the Committee
3. General Introduction by the Director
4. Summaries of Findings, Conclusions, and Recommendations

TO THE HONORABLE, THE BOARD OF ESTIMATE AND APPORTIONMENT.

Gentlemen:

The Committee on Inquiry into the Departments of Health, Charities, and Bellevue and Allied Hospitals, appointed in accordance with a resolution of your Board on October 26, 1910, herewith submits its report.

For reasons of economy and convenience the various sections have been published as monographs, for distribution to those who may be interested in the particular subject of a section, and have been submitted to you from time to time.

Respectfully submitted,

GEORGE MCANENY, Chairman,
President of the Borough of Manhattan

GEORGE CROMWELL,
President of the Borough of Richmond

NEW YORK, December, 1913.

INTRODUCTION

INTRODUCTION

By

THE COMMITTEE

The investigation assigned to this Committee by the Board of Estimate and Apportionment deals with a field having no established standards. No standards exist by which to judge the efficiency of hospital practice or of almshouse operation. Even the amount of food required by patients or inmates seems not to have been determined. Experts do not exist who could test the operation of our institutions by a cursory survey and comparison with similar institutions. Under the circumstances, it seemed advisable to the Committee to select for the inquiry an experienced investigator, and one familiar with institutional problems. Accordingly, Mr. Henry C. Wright, of the Russell Sage Foundation, was selected. Mr. Wright had made an extended examination of the fiscal control of state institutions in several states, an investigation which has influenced in many states legislation dealing with institutions. Mr. Wright was made Director of the investigation and called about him a staff of men, each familiar with certain phases of institutional work. He has consulted constantly with leading physicians in this and other cities, and his conclusions and recommendations have been much influenced by their advice. His conclusions and recommendations we indorse, and submit them as of the Committee.

The Report contains many recommendations, varying in importance, some providing administrative changes and some establishing standards; such as, ratio of nurses to patients, organization of an out-patient department, amount of food to be provided, building costs, salary and wage schedule, etc. Of the various recommendations, we wish especially to call attention to and emphasize the following as being of fundamental importance.

1. *Reorganization of the Medical Service of Bellevue Hospital*

The medical service in Bellevue Hospital is largely rendered gratuitously by physicians and surgeons who are engaged in private practice. Some of the best practitioners in the City are in attendance and the quality of service rendered is of the highest. However, owing to the fact that these physicians and surgeons have a large private practice which must be attended to, the time which they are able to devote to the Hospital is somewhat limited, and for a greater portion of the time the patients are in charge of the internes, who are recent graduates of medical colleges and inexperienced in the diagnosing of disease and in the care of patients.

The examination made by the Committee of the condition of discharged patients, the length of stay of patients, the character of clinical records, the autopsy findings, and the time rendered by attending physicians, made it clear that a more continuous oversight is needed by experienced and highly trained men. The Hospital cannot render

a satisfactory service without this oversight. The attending staff cannot be expected to give much more time than at present given, without sacrificing their private practice, resulting in a lessened income. It seems necessary, therefore, for the City, in order to secure the service imperatively needed, to compensate the physicians and surgeons in charge of the Services. This compensation will enable them to give not less than four hours daily to the patients. The City must maintain a better control over the operation of the Hospital than heretofore, and payment of the Chiefs of the Services by the City will insure such control.

Owing to the limited time which could be rendered by the attending staff comparatively little study has been given in Bellevue to the nature and causes of diseases. This is very important, since Bellevue, with its wealth of material, should be the leading laboratory of medical study in the United States.

On recommendation of the Committee, $29,500 was included in the budget for 1914 for the purpose of this reorganization. This amount of money is to be devoted to salaries of Chiefs of Services and Resident Physicians and Surgeons in accordance with the plan of reorganization outlined by the Committee.

It is the Belief of the Committee that Bellevue reorganized will be one of the most efficient hospitals in the United States, and by its example will raise the standard of efficiency in all municipal hospitals.

2. *Proposed Health Center*

The investigation has made it very evident that great numbers of patients are sent from our hospitals to their homes before recovery is completed and while in a weak condition. Comparatively little is known about these homes; whether the conditions will speed or retard convalescence; whether the resources of a family will enable it to support the convalescing patient. We know nothing of the homes whence patients come to our hospitals; whether the homes or working conditions have been largely contributory to the sickness. In short, we are working rather blindly within the walls of our hospitals, little knowing whence the patients come or whither they go.

The hospital must do some form of field work, in addition to the social service work now carried on in a limited way, in order to become an institution efficient in the prevention and care of disease.

To meet the conditions noted above the Committee has proposed that the City establish a Health Center, in which both the Health Department and Bellevue Hospital shall coöperate. The Health Center has not been provided for in the budget, but funds should be appropriated and the experiment started as soon as practicable.

3. *Long Term Children's Hospital on Blackwell's Island*

The Children's Hospital on Randall's Island has never been a satisfactory hospital. Children sent there have received inadequate attention. This has been due in a large measure to the inaccessibility of the Island. The Island is so located that, in all probability, it will in the future, as at present, have no better means of access than a ferry. The children of the City very much need a hospital for long term cases. Such a hospital should be located where it is easily

accessible to attending physicians and parents, and where good air and open space abound. Blackwell's Island, with bridge connection, provided elevators are built, fulfills these conditions.

It is the recommendation of the Committee that such a hospital be started on Blackwell's Island as soon as elevator connection is assured.

4. *Physical Examination and Employment of Inmates of Our City Homes (Almshouses)*

The inmates of our City Homes are seldom given a thorough physical examination. Such as are put to work are assigned without accurate knowledge as to their strength. The Committee had a full physical examination made of about five hundred men in the Home on Blackwell's Island. It appears from this examination that there are in our almshouses fully fifteen hundred inmates able to do light mechanical work who at present are doing nothing. These people would be happier and physically better if employed. The Committee recommends the installation of sufficient devices and machinery to provide occupation for these inmates. The physical examination to be given to all inmates will guard against an assignment which might overtax their strength.

5. *Hospital Helpers*

The low paid hospital employees are classed as Hospital Helpers, and their work ranges from menial labor to work in connection with the care of patients. Many have served for $60 per year. Within the last two years this lowest grade of pay has been practically discontinued, leaving the minimum at $120 per year. The very low pay secures a vagrant class, subject, in a large degree, to periodic drunkenness.

A study was made by the Committee to determine what effect any increase in pay had produced upon the character and stability of service. As a result of this study, which required several months of work, a schedule of wages is recommended which raises the pay of all persons caring for the sick. Under this new schedule no person receiving less than $360 per year, except pupil nurses, will render any service to the sick in the hospitals. The number thus serving was materially increased and the whole nursing service improved. This increase was accomplished without an increase in the total expenditures of the hospitals. The funds needed were secured by reducing the number of firemen, of whom there were many more than were needed.

If the economies recommended by the Committee be enforced with regard to the handling of supplies and food, and with regard to collecting for the care of non-residents and deportable aliens, the saving to the City will much more than offset any expenditures required for the purpose of putting the constructive recommendations of the Committee into operation.

GENERAL INTRODUCTION

By

HENRY C. WRIGHT, *Director*

In preparation for this investigation a detailed schedule of the lines of inquiry which might be profitably undertaken was made. As the work progressed, however, it became apparent that only a portion of the schedule could be carried out and it became necessary to make a choice of subjects. The subjects selected were, in the main, those on which fundamental recommendations might be made; recommendations which, if carried out, would automatically correct many minor defects in organization and administration.

In connection with the Department of Public Charities the first subject considered was that of Hospital Helpers, which classification includes practically all low paid help in and about the institutions. Serious complaint had been made year by year as to the inefficiency and unreliability of this low paid help, and repeated endeavors had been made to gradually increase the rates of compensation. An inquiry was made to determine whether or not such increases as had been made resulted in a better class of help and more constant service. This inquiry lasted several months and on its findings budgetary recommendations were made. Much time was devoted to the formulation of these budgetary recommendations, which were incorporated in the budget of 1913 but do not appear in the Report. Additional nurses and attendants were provided and the minimum wage of those serving in wards was materially increased, with the result that the standard of service in connection with the sick was raised in all of the hospitals of the Department of Charities.

An examination of the medical service in the hospitals of the Department of Charities was not made, except, in a very minor degree, in connection with Kings County Hospital. It became evident early in the investigation that a detailed examination of the results of medical and surgical practice could be made thoroughly in connection with only one hospital. For this purpose Bellevue Hospital was selected, in the belief that if the practice in the largest and one of the best of the City hospitals could be thoroughly analyzed the recommendations resulting therefrom would be applicable, in the main, to all of the hospitals, and the same methods of inquiry could be subsequently adopted in determining the efficiency of the medical service in each of the municipal hospitals.

Inasmuch as the treatment of children has become a specialized practice, quite distinct from the treatment of adults, it was deemed advisable to examine the children's services in a number of the municipal hospitals, in order that the problem of the care of children might be considered as a whole.

The method of handling the food within the hospitals was given consideration. Inasmuch as the Comptroller's Department is responsible for checking the amount and quality of food received that phase of the subject was not examined, but the amount of food used and the method of dis-

tributing and serving were examined in some detail. Bellevue Hospital was selected for this detailed inquiry; first, because hearty coöperation could be secured in that institution in carrying out recommendations, and, second, the results obtained in Bellevue might subsequently be applied in other institutions.

The character and costs of buildings were examined, not for the purpose of criticizing existing buildings in the hope that faulty planning and construction might be corrected by alteration, but rather in the hope that revealed defects in existing buildings might be avoided in those yet to be planned.

Considerable time was devoted to an analysis of the practice in the out-patient departments, and for this purpose Gouverneur Out-Patient Department was selected. In examining the results of this service and the condition of patients discharged from Bellevue Hospital it became evident that little is known with regard to home conditions of patients visiting our public institutions, and it seemed, therefore, desirable to make an intensive study of sickness in the homes in certain selected districts. As a result of the findings in connection with the condition of discharged patients, both from the hospitals and from the out-patient departments, a recommendation has been made for the establishment of an experimental Health Center, which is designed to make more effective the treatment given in the hospitals.

The administrative work of Bellevue Hospital was examined, and a new system of internal control forms was formulated and recommended. This internal control system, with some modifications, can be adapted to each of the municipal hospitals.

When the investigation started it was intended to make a thorough examination of the nursing service. Search was made throughout the United States to find a person competent to undertake such an inquiry, but no suitable person could be found who was in a position to engage in the work. Accordingly, the only phase of nursing work investigated was the ratio of nurses to patients now existing and that which should exist. In this connection a schedule has been devised which, it is hoped, may serve as a basis for estimating the number of nurses needed for municipal hospitals varying in the number of admissions and degree of acute and chronic service.

An extended inquiry was made to determine the number of aliens and non-residents cared for in our hospitals and almshouses. This inquiry was made primarily for the purpose of ascertaining to what extent New York City is bearing a burden which should be borne either by the Federal Government or by districts outside of New York City. It is hoped that the results will form a basis for legislative action which will ultimately greatly reduce the burden borne by New York City for the care of this class of patients.

A superficial examination of the City Homes (almshouses) made it apparent that little was known as to the actual physical condition of the inmates, and that large numbers were idle who could readily do some kinds of light mechanical work. To determine the physical condition of the inmates and the proportion that might be employed a thorough physical examination was made of about 500 male inmates in the City Home on Blackwell's Island. The results of the examination make it apparent that large numbers who are not now employed can do light work.

A great amount of time and labor was put forth in examining the

results of medical practice in Bellevue Hospital. These results were tested by determining the length of stay of cases with different ailments; the condition of patients on discharge to their homes; the diagnoses of readmitted patients compared with their previous diagnoses; the character of clinical records; the nature of autopsy findings as compared with clinical diagnoses; the time rendered by attending physicians; etc. These findings have been worked up in great detail, involving several hundred typewritten pages of tables and text, and have formed the basis for the recommendation of a somewhat radical reorganization of the medical service in Bellevue Hospital. This reorganization involves an expenditure on the part of the City of $29,500 annually, which amount has been provided in the budget for 1914. The reorganization seems necessary and highly advisable, and it is believed that the results obtained by the reorganization will be so pronounced and beneficial that they will raise the standard of hospital practice in all of the municipal hospitals.

Free access to all records and most hearty coöperation were rendered by the officials of the Departments of Health and Bellevue and Allied Hospitals. The coöperation was not so free on the part of the Department of Public Charities, yet sufficiently so to enable the Director to secure most of the information needed.

Many important matters have not been examined during the investigation, as previously stated, because of lack of time. The Committee received a pressing and cordial invitation on the part of the Commissioner of Health to make a full inquiry into his Department, but the only recent activity of the Committee in that Department was in connection with food and buildings. The Committee could have been of marked service to the Department of Health in studying the correlation of the different bureaus in the Department and the results of the work of each. A study of the lack of joint action, and of possible and advisable coöperation between the Health Department and other departments should be fruitful; such as, how school children may be most advantageously examined; how the Tuberculosis Hospital Admission Bureau may be best administered; how the ambulance service should be operated; how tuberculosis and other contagious or infectious diseases should be cared for.

The Comptroller's department has given much valuable consideration to accounting systems in connection with the public institutions, but little attention has been given to internal control. All of the City's public institutions are especially deficient in an internal control system, and much study is needed along this line. The consumption of foods and materials should be standardized in connection with the institutions, and a reasonable ratio established for each article. Such a study would require a great amount of time, but would result in marked economy, and would be of greatest value in formulating budgets.

Efficiency tests for the results of both surgical and medical practice should be devised, in order that the City may know in what degree its public institutions are serving the purpose for which they are supposed to exist. At present there are no such standards even in connection with private hospitals, but some of our leading surgeons and clinicians believe that some standards of testing efficiency are feasible and desirable.

A study should be made to determine what kind of data is necessary on which to base a judgment as to the need for new hospitals, and as to their advisable location. The projected rapid transit system which is under construction will shift centers of population and such new centers must be

served with hospital accommodations. How such accommodations may be furnished should be carefully studied.

It is of utmost importance that some department or individual be entrusted with the task of seeing that the recommendations of this Report are carried out. This involves coöperating with the departments to bring about certain internal administrative changes and reorganizations, and the drafting of bills and securing their enactment by the State Legislature, and consultation with Federal authorities to the end that the Federal law may be amended in certain particulars and departmental regulations modified.

Many things recommended in this Report have been brought about during the period of the investigation. From time to time suggestions have been made to the departmental heads, and in quite a good many instances such suggestions have been acted on. Special reference should be made to the more careful distribution of food in Metropolitan Hospital; the painstaking experiment in the distribution of food in Bellevue Hospital, resulting in marked reduction of the amount of meat used; certain changes in the method of caring for children in several of the hospitals. A large proportion of the lame, the halt, and the blind were removed from Farm Colony, and instructors of industrial work were asked for in the budget of the Department of Public Charities and an appropriation was granted therefor.

In connection with each subdivision of the Report there are a summary of findings, conclusions, and recommendations, which in this bound volume have been brought forward as part of the first section of the Report. The summaries of findings are designed to set forth some of the salient facts only, and these facts are stated so briefly that in many cases, in order to gain a full understanding, it will be necessary to refer to the body of the Report for an amplification of the facts. Nevertheless, a fairly clear idea of the scope and trend of the Report can be secured by reading the summaries of findings only. Some parts of the Report are in the nature of recommendations, and cannot readily be summarized, as, for instance, Suggestions for the Organization of an Out-Patient Department and Proposed Reorganization of the Medical Service in Bellevue Hospital.

In reaching conclusions and formulating recommendations I have been largely guided by the counsel of a number of our leading physicians and educators. Without specific reference, I desire to express my appreciation of their counsel and advice.

I desire to acknowledge the loyal and hearty coöperation of my staff, with special mention of the heads of divisions of work:

Dr. L. L. Williams, U. S. Public Health Service.

Dr. John H. Carroll, Instructor, New York and Bellevue Medical School.

H. B. Dinwiddie, formerly Chief Investigator for Bellevue and Allied Hospitals.

Edward F. Stevens, Hospital Architect, Boston.

John P. Fox, Housing Expert.

Charles G. Armstrong, Consulting Engineer.

R. H. Dillingham, Certified Public Accountant.

Raleigh Weintrob, Investigator of Sickness in the Homes.

F. E. Brooke, Investigator of Administrative Problems.

Nicholas Hansen, Investigator of Out-Patient Department.

SUMMARIES OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

ALIENS, NON-RESIDENTS, AND STATE POOR IN CITY INSTITUTIONS

A. Summary of Findings:

Aliens

1. To determine the number, length of stay in the United States, and physical condition of aliens, the records in Bellevue Hospital for the year 1912 were examined, and also the records in City Home, Blackwell's Island, for a given period.

To supplement information in the records, the patients admitted to Bellevue Hospital from May 19 to June 18, 1913, were physically examined, and were questioned as to citizenship and social conditions (page 141). For a like purpose, the friends or relatives of inmates in City Home, Blackwell's Island, were visited in connection with about 800 cases.

The examination of these patients and inmates revealed the fact that many more aliens were admitted to these institutions than shown by the records, probably owing to the fact that incorrect or insufficient information was secured from the patient or inmate on admission to the institution. The following estimates as to the number of aliens cared for by the City and the cost of their maintenance are based upon information obtained directly from the patients and inmates, their relatives and friends, and from the records.

2. Of the patients admitted to Bellevue Hospital during the month above indicated, 30.6 per cent. acknowledged that they were not citizens of the United States. The aggregate cost of supporting these patients up to September 9, 1913, was about $18,080. Bellevue Hospital received but $119 from all sources for the care of these aliens. On the basis of this ratio the cost of maintaining aliens in Bellevue Hospital alone for a year would aggregate about $265,777. (Page 143.)

Of the total admissions to Bellevue, 13.6 per cent. were deportable under the Federal and State laws. These clearly deportable cases cost Bellevue for maintenance, up to September 9, 1913, $7,500, with but $16.50 received as reimbursement. The cost to Bellevue of maintaining aliens removable under Federal and State laws for a year would be about $110,000. For the support of aliens having been in the country less than 3 years the estimated cost to Bellevue for maintenance would be about $84,000 annually, and of

this amount about $47,000 could be attributed to aliens deportable under the State and Federal laws. (Pages 143 to 146.)

3. Of all admissions to Bellevue, 4 per cent. were aliens who had conditions which, under the Federal Immigration Law, made their exclusion from this country mandatory. These mandatory cases in the course of a year may be estimated to cost Bellevue about $34,000.

4. But 10 per cent. of the patients that were mandatorily excludable seemed to have entered the country through oversight on the part of the examining physicians at Ellis Island. Ninety per cent. of these excludable aliens were not excluded by the examining physicians at Ellis Island probably because of a lack of examining physicians, interpreters, and suitable accommodations for the examination of aliens. (Page 148.)

5. The cost to the City of maintaining aliens in the almshouses is estimated to be about $172,000 annually, according to the findings for the period investigated. This amount exceeds by $90,000 the amount that it would cost if the aliens in the almshouses bore the same ratio to the total almshouse population as aliens bear to the total population of the City. (Page 155.)

6. Previous to 1876 the State of New York was in charge of the admission of immigrants, and, from a fund provided by a head tax, agreed to pay for the support of all sick and pauper immigrants within a period of 5 years after landing. The Federal Government took over the Immigration Service in 1882, and thereafter made contracts with the State of New York for the care of sick and pauper aliens, which contracts were in force until 1891, when they were discontinued. Since that time New York City has received a negligible amount for such aliens from the Federal Government. Similar contracts were made by the Federal Government with the State Board of Charity of Massachusetts, continuing in force until 1911. (Pages 108 and 112.)

The head tax which formerly was collected as an insurance fund with which to provide hospital or almshouse care for aliens is now turned into the Federal Treasury. The head tax is sufficient to cover the operating expenses of all immigration stations and to leave in the Federal Treasury over $1,000,000 annually.

The United States Department of Labor, under date of December 24, 1913, notified officials of New York City that, beginning with January 1, 1914, the Federal Government would not pay for the care of aliens in the municipal institutions who had become public charges from causes existing prior to landing.

7. According to the reports of the State Board of Charities the Federal Government removes but few aliens from the institutions of New York City. For the year ending September 30, 1912, it removed 44 aliens, and but 7 of these were removed from Bellevue and Allied Hospitals. At the same time 688 aliens were removed through the State Board of Charities. (Page 199.)

8. Previous to 1906 the Department of Public Charities, according to its reports, transferred deportable aliens directly to the Federal authorities at Ellis Island. In 1902 there were 1,137 aliens thus transferred. In 1906 the Commissioner of Charities issued an order that aliens should be reported to the State Board of Charities for investigation and removal. Since that year the number of aliens removed has been fewer than under the former plan. (Page 49.)

9. The estimated cost of caring for aliens in the municipal hospitals of New York City (exclusive of the hospitals in the Health Department and those on Randall's Island) is about $916,800 annually. The cost of caring for aliens in the almshouses is about $172,000 annually, or an aggregate cost of over $1,000,000 annually. This amount does not include the cost to the City of supporting aliens in private institutions. The estimated cost to the City of caring for those patients in the foregoing hospitals (excluding the almshouses) who have been in this country less than 5 years is about $386,700 annually.

Non-Residents of New York City

1. In 1912, according to the records of Bellevue Hospital, there were 2,431 admissions of non-residents of New York City. These patients cost the City for support not less than $47,600. The Hospital received as reimbursement for their support only $1,039. (Page 125.)

2. The reëxamination of patients in Bellevue made by the Committee, heretofore referred to, made it clear that the records of Bellevue do not contain full and accurate information with regard to the number of non-residents cared for. According to the number discovered by the Committee, an estimated total entering Bellevue during a year would be in the neighborhood of 5,500, and would cost the Hospital for maintenance at least $112,000. (Page 151.)

3. Of the 2,431 admissions of non-residents shown in the records, 1,148 were of patients who walked to the Hospital and 802 had been in New York State less than 60 days. (Page 127.)

4. Of these non-residents, 21.8 per cent. had been in the City 1 day or less; 26.4 per cent. 3 days or less; 33.3 per cent. 1 week or less; 47.7 per cent. 1 month or less. (Page 139.)

5. Judging by the character of the diseases and the length of time in the City, it is strongly probable that fully 67 per cent. of the non-residents had the ailments which caused them to be in Bellevue before they came to New York City. (Page 131.)

6. The State Board of Charities is charged with the duty of removing non-residents of the State from the public institutions of this City. From May 19, 1913, to June 18, 1913, the Committee found 322 non-residents of New York State in Bellevue Hospital. Of these the State Board of Charities removed 7. (Table XL.)

7. During the month of May, 1911, Bellevue Hospital referred 388 cases of aliens and non-residents to the State Board of Charities. Of these, 21 were removed and 179 were not examined. (Page 139.)

8. A dependent person who has not resided 60 days in any county of the State is classed as a State Poor person, and the State assumes the responsibility for the care of such dependents and is supposed to pay for their support in almshouses designated by it as State Almshouses.

The average number of State Poor annually acknowledged and supported by the State through the agency of the State Board of Charities for the 6 years preceding 1899 was 2,014. Since 1900 the number acknowledged and supported has gradually decreased, until the average number from 1905 to 1911 was but 575 annually. Thus, an increasing number of State Poor are apparently being supported in the institutions of New York City without reimbursement by the State. The City received for such support in 1902, $5,500, and in 1912, $600. (Page 157.)

In 1902 43 per cent. of the total amount paid by the State Board of Charities for the support of State Poor was paid to New York City. In 1911 New York City received but 14 per cent. of the total amount paid in the State by the State Board of Charities. (Page 157.)

B. Conclusions:

Aliens

1. Many thousands of dependent aliens who are a proper charge upon the steamship companies that have brought them into this country, or upon the Federal Government, not only are a heavy burden upon the City of New York for maintenance in public institutions, but they also occupy beds to the exclusion of many citizens of New York City who are in need of custodial or medical care.

2. A careful physical examination of aliens in Bellevue Hospital made by physicians employed by the Committee indicates that a large proportion of these aliens were afflicted with the ailment which caused them to be in Bellevue before coming to the United States. In most cases these ailments could have been detected at Ellis Island had the United States Public Health Service had sufficient inspectors and facilities to enable them to make more searching examinations.

3. The lack of a sufficient number of medical inspectors at Ellis Island has resulted in an inadequate examination of alien seamen, and many of these seamen have become dependents in our public institutions.

4. Comparatively little relief has been given the City by the removal of aliens from its institutions by the United States Immigration Service. This is probably due to the fact that not enough men are employed in this Service, and that the process of confirma-

tion and certification is so involved as to result in a long delay; during which period of delay the expense of maintaining dependents under investigation falls upon New York City.

5. Formerly the United States Immigration Service recompensed New York City for deported aliens from the time they entered an institution to the time they were removed. Under the regulation now in vogue (previous to December 31, 1913) the City receives payment only from the time that the United States accepts them as dependent aliens, and this acceptance is made only after an investigation, which may cover quite a lengthy period. This change in the period of payment has resulted in an additional expense to New York City.

6. Previous to 1906 the Department of Public Charities transferred dependent aliens direct to Ellis Island. Since that year it has been the regulation of the Department of Charities to report dependent aliens to the State Board of Charities for inquiry and action. As a result of this change fewer aliens are deported, and those that are deported remain a charge on New York City a much longer time. The order of the Department of Labor referred to in paragraph number 6 of the Summary of Findings deprives New York City of the small remaining recompense mentioned above.

7. The State Board of Charities has not fully exercised the function of removing aliens delegated to it by law. It has, in known instances, failed to examine a substantial proportion of the aliens referred to it for investigation for deportation, and has, in other instances, removed only a small proportion of cases that seemingly should have been removed.

8. The burden of proof as to whether or not a dependent is an alien and not entitled to support rests upon the officers in charge of the public institutions. That they have not thus far met this responsibility is evident from the large number of aliens found in the institutions. The failure to meet this responsibility not only costs the City many thousands of dollars yearly, but reduces the amount of accommodation that otherwise would be available for citizens in need of help.

9. Although by the Charter of the City of New York the Commissioner of Public Charities is directed to investigate the legitimacy of the dependence of all applicants for admission to institutions under his control, the authority for the removal of such aliens, non-residents, and State Poor dependents is not clear, and insufficient funds have been provided for making investigations and for the payment of transportation expenses.

10. The present power of removal vested in the State Board of Charities has not afforded adequate relief for the City, nor does it seem likely to do so.

Non-Residents

I. *Non-Residents of New York State*

1. The facilities afforded in New York City, and the freedom with which non-residents of New York State are admitted into its municipal institutions, have resulted in the dependence of large numbers of these non-residents upon the City.

2. A substantial majority of the non-residents of New York State admitted to Bellevue Hospital were aliens as well as non-residents.

3. Non-residents of New York State occupy many beds in our municipal institutions to the exclusion of needy citizens.

4. The lack of provision in the law of this or of adjoining states to enable this State to deport dependent non-residents to the state to which they belong, makes it difficult for our municipal institutions to discharge non-residents once they have been admitted.

5. The difference between the laws defining the settlement necessary for maintenance as a poor person in the State of New York and in the adjoining states makes it possible for a person who is not a resident of this State to become dependent here without having a settlement in the state from which he came.

6. In the State of Massachusetts justices are empowered to order the removal of non-residents. Were such a law in force in New York State this City would save many thousands of dollars annually.

7. The power of removal of non-residents is given to two State Boards in New York; namely, the State Board of Charities and the State Hospital Commission. The State Board of Charities has removed only a small proportion of the non-residents from Bellevue Hospital which the records appear to show might properly have been removed. It has removed comparatively few of the cases referred to it for removal by the Department of Public Charities.

II. *Non-Residents of New York City*

1. Non-residents of the City, although residents of the State, have been freely admitted to municipal institutions, and have been maintained there at heavy expense. In the State of Massachusetts action may be brought by the Poor Law officers in a locality in which a poor person with settlement elsewhere becomes dependent, for the recovery of the expense of his relief from the place of his settlement. In the State of New York, according to the interpretation of the Supreme Court, this can be done only when the dependent had become a "poor person" before leaving the place of his settlement. A municipality in New York State, under the existing laws, has not the equal legal facilities for relieving itself of non-residents having a legal settlement within the State that it has of relieving

itself of non-residents not having a legal settlement within the State. The lack of a clear and adequate provision touching these matters in New York State bears heavily on New York City.

2. It is clear, since over one-half of the non-resident patients of Bellevue walked to the door of this institution, that regulation of admission is lax. This is emphasized by the fact that the length of stay in the City of the majority of the non-residents of the City previous to admission to Bellevue was of short duration, a substantial proportion having been in the City only 1 day or less.

3. Since a large majority of the non-resident United States citizens admitted to Bellevue Hospital in 1912 appear to have contracted the ailments which caused their dependence before coming to the City, they could lay little claim to the hospitality and care of New York City.

4. The Board of Trustees of Bellevue and Allied Hospitals has made no attempt to collect the expenses of non-residents of New York City maintained in its institutions from the places of their legal settlement within the State, and it is questionable whether they have authority to press such claims. If a sum proportionate to that collected by Boston City Hospital from Massachusetts and from counties and towns of that State were collected by Bellevue Hospital for patients not having a legal settlement in the City, it would receive annually not less than $200,000 from New York State and its subdivisions.

III. *State Poor*

1. The State Board of Charities has reported from 1902 to 1911 as State Poor only about one-half of the number of cases classed by the Department of Public Charities as State Poor in its Annual Reports.

2. The State Board of Charities in recent years has maintained and reported annually a very much smaller number of State Poor cases throughout the State than for many years previously. The average number of State Poor cases maintained annually is less than was maintained 30 years ago.

3. The payments by the State Board of Charities to New York City for the maintenance of State Poor have diminished greatly in the last 10 years. Of the total amount paid to the entire State, the proportion paid by the State Board of Charities to New York City for the maintenance of State Poor has greatly decreased. The proportion of removals by the Board from New York City as compared with the number removed from the entire State is only about one-half what it was 10 years ago.

4. The provision made in the State Poor Law that all State Poor shall be maintained at State Almshouses excludes those necessarily maintained in hospitals. This provision burdens the City without recompense.

C. Recommendations:

Means of Reducing the Burden upon the City for the Care of Aliens and Non-Residents.—Immediate, though Partial

1. Establish at Bellevue a bureau to perform the following functions:

(a) To have charge of that portion of the admission work which deals with the social condition and history of applicants. A representative of the bureau should attempt to secure from each applicant, exclusive of emergent cases, the facts pertaining to his nativity; length of residence in the United States; in New York State; in New York City; whether or not naturalized; and should inquire as to facts relating to his dependence.

(b) To make inquiry of patients in the wards from whom satisfactory information could not be gained at the time of admission covering the foregoing information.

(c) By means of field investigators, to secure the information above indicated from friends or relatives when full and satisfactory information cannot be secured from the patients.

(d) To collect from patients able to pay for their treatment.

(e) To collect from officers outside of New York City responsible for the care of dependents that may have entered Bellevue and Allied Hospitals, after the law has been so amended as to make such responsibility clear. (This relief would not be immediate, but might be obtained within a year if legislation could be secured during the coming session of the Legislature.)

(f) To communicate with State officers responsible for the State Poor and removal of non-residents, and with Federal officers responsible for the care and deportation of aliens.

(g) To have charge of all statistical records of the hospitals.

The organization and method of procedure of such bureau to be as follows:

(a) The bureau to be in charge of a high class man versed in social work and social needs, and statistical methods.

(b) The staff, in addition to the chief, to consist of a representative at each of the allied hospitals; field investigators; a statistical clerk; and a stenographer.

(c) The representative at each of the allied hospitals to participate in the work of admission; to make inquiries of the patients in the wards; and to transfer to the head officer at Bellevue names of patients for removal by the State or Federal authorities and those for field investigation. All field investigations to be made by investigators from the main office at Bellevue, and all statistical matter from the allied hospitals to be worked up at the main office.

The estimated budget for the above bureau is as follows:

1	chief of the investigating bureau	$3,000
1	stenographer	720
1	statistical clerk	900
5	admitting officers @ $1,200	6,000
4	field investigators @ $1,200	4,800
		$15,420

The expenditure of the above-indicated amount of money should save Bellevue and Allied Hospitals annually several times the amount expended. It is probable that such a bureau, aside from excluding many non-residents who should not be treated by the City, and securing the deportation of aliens afflicted with sickness before entering the country, would collect from other states; from New York State; from subdivisions of New York State; from individuals; and from the Federal Government. Such collections would amount to many thousands of dollars annually.

2. Aid in securing a larger appropriation for the use of the State Board of Charities; to be used:

(a) for the removal of non-residents and aliens from our public institutions;

(b) for the support of the State Poor.

3. Reëstablish the system formerly in operation of reporting directly to the Federal authorities at Ellis Island, instead of through the State Board of Charities, all aliens found to be dependents.

4. Bring to the attention of the Federal authorities at Washington the need for additional help and facilities at Ellis Island, as follows:

(a) Additional examining physicians in the Public Health Service.

(b) Increase in facilities for the detection of all organic diseases and mental defects, and additional detention rooms for observation in all classes of cases.

(c) Interpreters for the medical service.

(d) Additional inspectors in connection with the examination of cases in hospitals and almshouses alleged to be deportable aliens.

Means of Reducing the Burden upon the City for the Care of Aliens and Non-Residents.—Dependent upon Legislative Amendments

1. The officer of the City who is, or becomes, Overseer of the Poor to be given power to investigate alleged alien, non-resident, State, County, and Town Poor in all of the institutions supported by the City, and City charges in private institutions. Also, power to take final action with regard to such patients, and, after the

laws have been amended in accordance with the following suggestions, to transfer aliens to the Federal Government; to transport non-resident, State, County, and Town Poor to the authorities legally responsible for their care; or to collect for their care in case they are dependents upon the City of New York.

2. Amend the law so that the State Poor shall include all public charges not having a legal settlement in some subdivision of the State, and make the proof of residence rest upon the State rather than the locality.

3. Amend the law so that the definition of County Poor shall include any dependent having a legal residence in a county of the State and not having acquired a residence elsewhere.

4. Amend the law so that County or Town Poor will be dependent upon the county or town wherein the dependent has a legal residence.

5. Endeavor to secure agreements on the part of the states adjoining New York State to accept dependents who have a legal residence in any subdivision of such states but who at the time may be a dependent in New York State or any subdivision of New York State.

Endeavor also to secure a common agreement on the part of these states as to the length of time in which legal residence may be secured, so far as such residence relates to dependence.

6. Endeavor to secure an amendment to the Federal law which will regulate the landing of seamen and provide for their examination previous to landing.

7. Endeavor to secure an amendment to the Federal law which will extend the period within which a dependent alien may be deported. It is suggested that a period of 5 years be given consideration.

8. Endeavor to secure a change in the regulations of the Department of Labor (which Department is in charge of the Immigration Service), so that the City may receive compensation for the support of dependent aliens from the time when they become dependents to the time of transfer to the Federal authorities.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

ADMISSIONS TO CITY HOMES (ALMSHOUSES)

A. Summary of Findings:

1. All admissions to City Homes (almshouses) are supposed to be made through Bureaus of Dependent Adults located in the different boroughs. (Page 249.)

2. Of the admissions to the City Home, Brooklyn, in 1911, 29.8 per cent. were made on transfer slips bearing the signature of the Superintendent of Kings County Hospital. There is no record to indicate that these transfers from the Hospital were subsequently confirmed by any other officer. (Page 271.)

3. The authorizations for admissions found on file at the Brooklyn Home for the year 1911 were 241 less than the number of admissions officially published in the *City Record*. (Page 270.)

4. Such admissions as were made from the Bureau of Dependent Adults in Brooklyn were passed upon by a clerk in the Bureau, and the admission permits were signed by no other officer than the clerk. (Page 271.)

5. Some admissions were made to each of the almshouses without any authorization on record in the almshouses or Bureaus of Dependent Adults. (Page 249.)

6. At the time of the inquiry of the Committee no centralized record existed in the Bureau of Dependent Adults, Manhattan, which would enable the Bureau to ascertain whether an applicant had at any previous time been an inmate of any one of the City institutions. Since the examination, and through the coöperation of the Commissioners of Accounts, a centralized system has been installed. (Page 259.)

7. The addresses of dependents and their relatives and friends, to be communicated with in case of necessity, in a large proportion of the cases examined were lacking, out of date, indefinite, or incorrect. (Page 252.)

8. The Examiners of Charitable Institutions connected with the Manhattan Bureau of Dependent Adults investigated less than 20 per cent. of the admissions to the Manhattan Home for the month of May, 1912. There is no evidence to indicate that any of the cases admitted to the Home in Brooklyn were examined by the Examiners of Charitable Institutions of the Brooklyn Bureau. (Page 255.)

9. The Bureaus of Dependent Adults in Manhattan and Brooklyn issued orders that no dependent having been sent to Farm Colony, or having refused to go there, should be readmitted to the City Homes in Manhattan or Brooklyn. (Pages 250 and 275.)

Of 554 dependents sent from the Manhattan Home to Farm Colony, 23 failed to arrive; of those arriving, 240 deserted; of the deserters, 103 were readmitted to the City Home, Manhattan; of those readmitted, but 17 were returned to Farm Colony; of those returned to the Colony, 10 deserted; and of the 10, 4 were again received in the City Home. The same condition of desertion and readmission existed in connection with the City Home in Brooklyn. (Page 258.)

B. Conclusions:

1. Heretofore in the Department of Public Charities, owing to the absence of a centralized record, it has been impossible to identify an applying dependent who at some previous time had been admitted through one of the Bureaus. Lacking such a record it has been possible for applicants who may have been rejected by one Bureau to make application at another Bureau and be admitted, or for applicants who had deserted from Farm Colony to secure readmission through the Bureau in Manhattan or in Brooklyn. As a result of its defective record system the Department of Public Charities has been receiving and caring for many inmates who were not legitimately dependent upon the City.

2. Owing to the lack of sufficient correlation between the Bureaus and other branches of the Department, and non-enforcement of its own regulations, dependents have been admitted by the Department of Charities through other than the regular channels, and without sufficient scrutiny and examination.

3. Owing to an insufficient number of field inspectors, failure to use the information on its own records, and failure to make thorough investigations, the Department of Charities has received, retained, and cared for a large number of aliens, non-residents, and persons whose support could have been borne by the localities of their legal settlement, by their relatives, or by their own resources. The lack of inspectors, and the failure to be guided by the information on the records and to require thorough investigations, have cost the City many thousands of dollars annually.

4. Discipline at Farm Colony has been made exceedingly difficult because of the fact that deserters from the Colony and insubordinate inmates who have been expelled have been freely permitted to reënter the Homes in Manhattan and Brooklyn.

5. The Department of Charities has not kept full history records of all inmates in the Brooklyn Home, as required by law. The lack of such records makes it difficult to determine the character of inmates in the Homes at any given time.

6. The records, especially in the Brooklyn Home, were so incomplete and fragmentary that the institution did not and could not

know on any particular day what inmates were in the institution. Such confusion in records seems unwarranted.

7. The records of the addresses of inmates and friends of inmates were not kept up to date. As a result, it would be easily possible for an inmate who had died to be buried in the Potter's Field without notification reaching the friends of such inmate.

8. When the City purchased the land adjoining Farm Colony it was with the purpose and intent that Farm Colony should care for and utilize the work of the relatively able-bodied dependents. The transferring in large numbers of the crippled and decrepit inmates to Farm Colony has, in a large degree, complicated the problem of operating the farm.

9. Voluntary charitable associations naturally possess records of many of the dependents in the City. The City is free to consult this information, and much labor and expense would be saved if the Department of Charities would avail itself of the information thus collected by private organizations.

10. Many private social agencies aim to do constructive and preventive work by restoring dependents to normal family and social relations; in handling the adult poor the Department of Charities has not sought the coöperation of these agencies in this work of rehabilitation.

C. Recommendations:

1. The City should supply the Department of Charities with sufficient investigators to enable it to fully examine the family circumstances and legal settlement of every applicant for admission to the City Homes.

2. The Bureaus of Dependent Adults should use all pertinent information upon the departmental records, and require thorough investigations to be made by the Examiners of Charitable Institutions.

3. The records of inmates should be kept with such fullness and accuracy that each institution would know at all times every inmate being cared for, the cause of his dependence, and the record of his previous economic condition.

4. No transfers should be made from the Municipal Lodging House or City Homes without a full knowledge on the part of the Commissioner of Public Charities of the physical condition of each inmate proposed to be so transferred.

5. The regulation should be strictly enforced that an inmate once transferred to Farm Colony should not be readmitted to the Manhattan or Brooklyn Home without the consent of the Commissioner of Public Charities.

6. The crippled and decrepit should be removed from Farm Colony, and hereafter only the relatively able-bodied transferred to that institution. The number, size, and character of buildings at Farm Colony should be adapted to this class of inmates.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

CLINICAL RECORDS IN BELLEVUE HOSPITAL

A. Summary of Findings:

1. A large number of the clinical records in Bellevue Hospital were examined by Dr. L. L. Williams on behalf of the Committee, and 135 of the records were reported in detail. Of this number, 57 per cent. were considered good by Dr. Williams; 30 per cent. were incomplete; and 13 per cent. were poor. (Page 352.)

2. The character of the records differs materially in the different divisions in Bellevue. One division had but 3 per cent. of poor histories, whereas another division had 36.5 per cent. of incomplete histories, and 27 per cent. of poor histories. (Page 352.)

3. The following cases are an illustration of some of the poor records kept:

Case 123. Abscess of Kidney.
Admitted Aug. 12, 1912.
Discharged Oct. 5, 1912.
Record of admission, physical examination, and operation, sufficient. X-ray record. Remainder of record by nurse. Result stated in caption only. Post-operative course can only be inferred from nurse's notes of "dressings changed, etc."

Case 1234. Lobar pneumonia; suppurative pleurisy; empyema; septicæmia.
Admitted Nov. 27, 1912.
Died Dec. 3, 1912.
Record of admission, physical examination, and laboratory examination, good. Remainder of record by nurse. There is no mention in the body of the report of the complication noted in the caption; viz., empyema.

A detailed presentation of the records examined will be found on pages 352 to 357.

B. Conclusions:

1. Some of the divisions in Bellevue Hospital keep reasonably satisfactory clinical records. One division has very poor records.

2. It was not determined whether the defects in the records were due to inefficient internes, or to the lack of supervision on the part of the attending physicians, or to both.

3. It is impossible, without full and accurate clinical histories, to give satisfactory treatment to patients who are attended by different physicians on different days, or in different periods, or who are discharged and subsequently return to Bellevue.

C. Recommendations:

1. Such supervision of the medical records should be established as to insure a complete and accurate record of the character and progress of each case.

2. When a patient is transferred from another hospital to Bellevue and from Bellevue to another hospital a copy of the medical record should accompany the case.

3. When the autopsy findings are made in case of death, corrections in the medical record should be made in such a manner as to indicate on the record that the corrected diagnosis is the autopsy finding, and the original diagnosis should be allowed to stand as a basis of comparison.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

AUTOPSY FINDINGS IN BELLEVUE HOSPITAL COMPARED WITH CLINICAL DIAGNOSES.

A. Summary of Findings:

1. Bellevue Hospital performs autopsies on about 10 per cent. of those dying in the Hospital. The University College Hospital, in London, performs autopsies on 84 per cent.; Allgemeines Krankenhaus, in Vienna, on 99.9 per cent.; and most of the German hospitals on over 90 per cent. of those dying in the institutions.

The number of autopsies performed on unclaimed dead bodies in Bellevue has gradually decreased, until practically none are performed at the present time. In 1909, 266 were performed; in 1912 only 12 were performed. (Page 362.)

2. This decrease and practical elimination of autopsies on the unclaimed dead in Bellevue are due to an order issued by the Commissioner of Charities on April 15, 1910, prohibiting Bellevue from performing autopsies thereafter on the bodies of the unclaimed dead. This order was based upon a report of a committee, which held that the law prohibited such autopsies. A minority report of this committee held that, though the law provided that unclaimed bodies should be turned over to medical colleges, autopsies might be performed upon such bodies previous to such delivery. (Page 363.)

3. The medical colleges claim that they need more than 1,000 bodies yearly for the purpose of teaching anatomy. According to the practice of leading medical colleges in the United States about 400 bodies should be sufficient for teaching purposes in the medical colleges, including post-graduate, of New York City. (Page 364.)

4. The autopsy findings in Bellevue for the year 1912 were compared by Dr. Horst Oertel with the ante-mortem or clinical diagnoses made by the physicians. His report has been summarized as follows:

Class			
I.	Clinical diagnoses confirmed	87	22.4%
II.	Clinical diagnoses correct but autopsies disclosed additional important lesions	116	29.9%
III.	Clinical diagnoses partly correct but other important lesions that had contributed to the diagnosed lesions were found	54	13.9%
IV.	Clinical diagnoses not confirmed	107	27.6%
V.	No clinical diagnoses in death records	24	6.2%
		388	100.0%

The diagnoses seem to have been incorrect in 47.7 per cent. of the cases. (Pages 365 and 366.)

B. Conclusions:

1. The percentage of autopsies performed in Bellevue and in most of the large hospitals in the United States is very small as compared with the percentage of autopsies performed in European hospitals, and it is very largely because of this fact that medical knowledge advances more rapidly in Europe than in the United States.

2. The very strict interpretation of the law governing autopsies made by the Commissioner of Charities has deprived Bellevue of much needed material, and has surrendered to the medical colleges an additional amount of material which seems not to have been needed.

3. The large percentage of incorrect clinical or ante-mortem diagnoses in Bellevue is partly due to the lack of medical knowledge among our better class of practitioners, and partly to hasty and insufficient examinations. Too much reliance upon inexperienced house physicians and internes also accounts for a portion of these errors.

4. A reasonable and satisfactory number of autopsies can be provided in our public hospitals only by a change in the law governing autopsies.

C. Recommendations:

1. It is recommended that the law governing autopsies be amended so as to enable the hospitals to perform a much larger percentage of autopsies than at present. Details of these recommendations will be found on pages 367 and 368.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

DISTRIBUTION OF WARD SPACE IN BELLEVUE HOSPITAL

A. Summary of Findings:

1. The number of vacant beds in a service necessary to provide for fluctuations, as established by Dr. L. L. Williams, is about 12 per cent. of the total number of beds in the service. (Page 372.)

2. During the fourth quarter of 1912 the male wards of the Medical Service in Bellevue had 25.1 per cent. of beds vacant; the female wards 20.3 per cent.; the Genito-urinary Service 27.8 per cent.; the female Surgical Service 14.4 per cent.

On the other hand the male wards of the Surgical Service were somewhat overcrowded, having had but 4.1 per cent. of vacancies. (Page 371.)

3. Although the male Medical Service had on an average a marked excess of beds, in certain divisions the beds were overcrowded.

In December, in the First Division 48.3 per cent. of the beds were vacant; whereas, during the same month, in the Third Division the vacancies amounted to but 9.1 per cent. During the same month, in the female wards the First Division had 36.6 per cent. of beds vacant; whereas the Third Division had but 6.8 per cent. This high percentage of vacant beds in the First Division as contrasted with the Third Division was noticeable during the 3 months of the quarter. (Pages 374 and 375.)

4. In the female wards of the Surgical Service the Third Division showed an average vacancy of beds of 24.3 per cent. during the quarter; whereas the Fourth Division had an average vacancy of but 6.9 per cent. (Page 376.)

5. In the Children's Surgical Services the average percentage of patients in excess of beds in the Second Division during the quarter was 21.7 per cent.; whereas the First Division had 1.7 per cent. of beds vacant, and the Fourth Division 4.4 per cent., and the Third Division 11.6 per cent. (Page 377.)

6. In the male Medical Service, including the four divisions, 25.1 per cent. of the beds were vacant; whereas, at the same time, in the Surgical Service, taken as a whole, the vacancies amounted to but 4.1 per cent. (Pages 371, 374, and 376.)

B. Conclusions:

1. There was a marked excess of beds in the Medical Service in Bellevue Hospital during the last quarter of 1912; whereas, at the same time, the wards of the Surgical Service were overcrowded.

2. It is very apparent that there may be many vacant beds in one division while at the same time there will be serious overcrowding in another division.

3. The system of assigning patients in rotation to the four divisions evidently operates in such a manner as to overcrowd the beds in some divisions and to leave vacant a large percentage of beds in other divisions.

4. There is apparently no attempt to transfer surgical cases from overcrowded wards to the vacant beds in the medical wards. Such transfer of patients takes place in many hospitals, and operates successfully.

5. No arrangement is made to transfer patients from the wards of a division which may be overcrowded to the wards of another division which may have an ample number of vacant beds.

C. Recommendations:

1. The distribution of patients should be so regulated, irrespective of divisions, as to more evenly distribute the patients throughout the hospital.

2. Inasmuch as some very successful hospitals transfer surgical patients to medical wards when the surgical wards are overcrowded and the medical wards have vacant beds it would seem feasible for Bellevue to adopt the same policy.

3. If patients were distributed to the different divisions in proportion to the number of beds assigned to those divisions, it would lessen the tendency on the part of any division to discharge prematurely uninteresting patients in order that vacancies might be made for the reception of more interesting cases. It would seem advisable and feasible to adopt some such method of distribution.

ARGUMENTS IN SUPPORT OF RECOMMENDATIONS

It is advantageous to the Hospital to have the medical colleges in charge of the medical service. The welfare of the patients, however, should be considered paramount to the interest of the medical schools, and it is not unreasonable to expect the medical schools to keep patients in their services a reasonable length of time, irrespective of whether such patients are or are not interesting cases. Unless the colleges are expected and required to keep patients as long as the Hospital authorities deem advisable and necessary, cases will continue to be discharged prematurely, and different wards will show varying percentages of vacant beds or of congestion.

It is, of course, desirable to keep all surgical patients together, but when the surgical wards are overcrowded it is much better to transfer surgical patients to medical wards than to discharge such patients prematurely. The Trustees should have full control of the distribution and assignment of patients, and it should be considered no injustice to any one medical school to expect it to transfer patients to another division if the division to which such transfer should be made has vacant beds and its own division is overcrowded.

If the principle that the interest of the patients is paramount to that of the medical schools be adopted and acted upon, methods can readily be devised which will more equally distribute the patients in the Hospital, thereby reducing congestion at certain places. This policy also would result either in retaining patients a longer time than they had previously been retained in the Hospital, or, if they are to be discharged as rapidly as heretofore, it would enable the Hospital, with a given number of beds, to care for many more patients than it has been caring for.

SUMMARY OF FINDINGS,
CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

TRANSFER OF PATIENTS TO AND FROM BELLEVUE HOSPITAL AND TO AND FROM KINGS COUNTY HOSPITAL

October, November, and December, 1911.

A. Summary of Findings:

Bellevue Hospital

1. During the three months October, November, and December, 1911, 1,597 patients were transferred to Bellevue Hospital by ambulances of other hospitals. Of this total number about 10 per cent. died. Although the death rate of these patients was 10 per cent., 17.7 per cent. of the patients transferred by Flower Hospital ambulances died. (Page 385.)

2. Of the transfers to Bellevue, 44 per cent. were alcoholics, insane, or tuberculous; 24 per cent. medical; 22 per cent. surgical; 9 per cent. miscellaneous. (Page 385.)

3. Of the total number of patients transferred to Bellevue, 52 per cent. remained less than 4 days. (Page 385.)

4. Of the total number transferred to Bellevue, 167 died. Of this number, 16 died on the day on which they reached Bellevue, and 76 others, or 46 per cent., within 4 days. (Page 386.)

5. Of the total number (1,723) transferred from Bellevue, 863, or about 50 per cent. of the patients transferred, had remained an average of less than 4 days in Bellevue. Of this number, 107 were transferred within 24 hours. (Page 386.)

6. Exclusive of tuberculosis, about 40 per cent. of the patients transferred to Blackwell's Island had remained in Bellevue less than 4 days. (Page 386.)

7. Of the tuberculous patients transferred from Bellevue, 65 per cent. had remained in Bellevue 4 days or less. (Page 386.)

Kings County Hospital

1. During the three months mentioned 172 patients were transferred from other hospitals to Kings County Hospital, as compared with 1,597 transferred to Bellevue from other hospitals. Of this number 27 per cent. died, as compared with 10 per cent. in Bellevue. (Page 388.)

2. Of the total number of patients transferred to Kings County Hospital, 42 per cent. remained less than 4 days, as compared with 52 per cent. for the same period in Bellevue. (Page 389.)

3. Of the 47 that died in Kings County Hospital, 4 had been in the Hospital but 1 day; 6 died within 48 hours; and 10 others within 4 days. In other words, 42 per cent. of the deaths occurred within 4 days from the time of reaching the Hospital, as compared with 28 per cent. dying within the same period in Bellevue. (Page 389.)

4. Of the total number (193) of patients transferred from Kings County Hospital to City Home, Brooklyn, 51 were diagnosed as "non curata," which term is interpreted by the Hospital as meaning that the patient was not sick. Nevertheless, 3 of these remained from 5 to 9 days, and 2 remained over 10 days in the Hospital before being transferred to the Home. (Page 389.)

5. Of 59 tuberculosis cases transferred from Kings County Hospital to Metropolitan Hospital, 30 had remained in Kings County Hospital more than 10 days, and 17 had remained from 5 to 9 days. (Page 399.)

B. Conclusions:

Bellevue Hospital

1. Flower Hospital has carried many patients in its ambulances to Bellevue Hospital when practically at the point of death.

2. The fact that 52 per cent. of the patients transferred to Bellevue from other hospitals remained in Bellevue less than 4 days indicates that, in a large measure, Bellevue is but a "way station" between private hospitals and some ultimate destination of the patients.

3. That 18 patients brought to Bellevue in private ambulances died on the day of arrival, indicates a marked tendency on the part of private hospitals to carry dying patients to Bellevue rather than to their own hospitals.

Kings County Hospital

1. The private hospitals in Brooklyn are evidently more prone even than some of the private hospitals in Manhattan to transfer patients at the point of death to Kings County Hospital.

2. The large number of "non curata" cases transferred from Kings County Hospital to the City Home indicates that the Hospital, in quite a measure, is a receiving department for the Home. Such admissions are supposed to take place through the Bureau of Dependent Adults in Brooklyn.

3. Kings County Hospital is not prepared to take care of cases of tuberculosis. The Hospital does not seem warranted in retaining tuberculous patients the length of time which the foregoing data indicate they have stayed.

C. Recommendations:

1. Section 1 of Chapter 748 of the Laws of 1907 provides that no hospital shall transfer a patient near the point of death except for good cause, which cause shall be set forth in a certificate signed by the attending physician or surgeon, or, in their absence from the hospital, by the senior member of the house staff. A penalty of $100 is provided for failure to comply with this Act. The Act, however, does not forbid the ambulance of a private hospital to carry a patient in a dying condition from a residence or the street to Bellevue rather than to the hospital which operates the ambulance. Such a regulation could appropriately be made by the Ambulance Board, and reports could be made by Bellevue with regard to its effectiveness. It seems highly advisable that a patient in a dying condition should be transferred to the nearest hospital, which, in most cases, would be the hospital operating the ambulance. This matter could probably be regulated, either by the Ambulance Board or by Bellevue, without additional legislation.

2. So far as possible, Bellevue Hospital should be relieved of the necessity of receiving a large number of patients from private hospitals who are destined to be sent within a few hours to the hospitals of the Department of Charities. These patients occupy many beds and quite a portion of the time of the help in Bellevue. So far as possible, these patients should be transferred direct from the private hospitals to the Department of Charities, or else they should be placed in a receiving ward in Bellevue provided for this purpose, and which would not require the clerical and other work necessary to admit them into Bellevue.

3. Inasmuch as Bellevue is not supposed to care for tuberculous patients, it seems advisable that patients known to have tubercu-

losis should not be received at Bellevue, but that they should be transferred at once either to the hospitals of the Department of Charities or the Department of Health.

4. The same statement about the reception of tuberculous patients by Bellevue may be made with regard to Kings County Hospital.

5. The admission, discharge, and transfer of patients involve much clerical and other labor on the part of the hospitals. So far as possible, immediately after diagnosis, patients should be assigned and delivered to the hospital which is to care for them throughout their sickness.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

THE MORGUE SERVICE

A. Summary of Findings:

1. The morgue service throughout the City of New York is conducted by the Commissioner of Public Charities. (Page 403.)

2. The morgue located on the Bellevue grounds received 11,697 bodies during 1911. It is inadequate, both in size and facilities. A new morgue, ample in capacity and splendidly equipped, has been constructed in connection with the pathological building at Bellevue. The Bellevue Trustees asked the Commissioner of Charities in January, 1912, to operate this new morgue, but it has not yet been put into operation. (Page 403.)

B. Conclusions:

1. The facilities afforded in the old morgue for performing autopsies are very inadequate, and autopsies cannot be satisfactorily conducted under existing conditions.

2. The new morgue in the pathological building has been lying idle for about two years since its completion. It should be put into operation.

C. Recommendations:

1. In June, 1913, the Commissioner of Charities submitted to the Secretary of the Borough of Manhattan a suggested list of helpers needed to operate the new morgue. The number of such helpers aggregated 34, and the total salaries, $21,060. It is recommended that the Commissioner of Charities be granted 23 helpers for the operation of the morgue, with salaries aggregating $12,480. A detailed list of these helpers will be found on page 404.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

RATIO OF NURSES TO PATIENTS PROPOSED FOR MUNICIPAL HOSPITALS

A. Summary of Findings:

1. No recognized ratio of the number of nurses to patients cared for exists in connection with the municipal hospitals. (Page 407.)

2. No standard exists by which the appropriating authorities of the City may judge whether or not a request for additional nurses for a particular institution should or should not be granted. (Page 407.)

3. During 1912, in Kings County Hospital there was 1 trained nurse to each 21 beds, with 14 admissions per bed per year. In Metropolitan Hospital, General Service, there was 1 trained nurse to each 24 beds, with 8 admissions per bed per year. In City Hospital there was 1 trained nurse to each 42 beds, with 8 admissions per bed per year. Bellevue Hospital, exclusive of special services, with about 950 beds and about 24 admissions yearly per bed, employed 1 trained nurse for each 16 beds. (Page 407.)

B. Conclusions:

1. There seems to be no reasonable ground why hospitals caring for the same class of patients should not provide the same ratio of nurses to patients.

2. The granting of a request from a particular hospital for an increase in the number of nurses should not depend upon the amount of influence which the training school or other officers of that hospital can bring to bear upon the appropriating authorities, but should depend upon a need which may be recognized and standardized.

3. All of the hospitals should be equipped to give equally good nursing service.

C. Recommendations:

1. A schedule setting forth ratios of nurses to patients in hospitals varying in size and in the number of admissions was drawn up and presented to some of the leading nurses of the country. It was the consensus of opinion of these nurses that a schedule of the general character of that presented would be practical and useful. This schedule is set forth on page 410. It is recommended that this ratio be recognized by the City as a basis for appropriating funds for the nursing service in the municipal hospitals.

SUMMARY OF FINDINGS,
CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

CHILDREN'S SERVICES

IN THE

MUNICIPAL GENERAL HOSPITALS IN MANHATTAN AND THE BRONX

A. Summary of Findings:

1. The ratio of nurses to sick children is much smaller in our municipal hospitals than in the best private hospitals. The ratio in The Babies' Hospital is 3 nurses to 9 children. In Harlem Hospital it is 3 nurses to 26 children; in Gouverneur Hospital 3 to 30; Metropolitan Hospital 3 to 26; and City Hospital 3 to 16. These nurses have no special training in the care of children. (Page 413.)

2. Only Bellevue, of all of our municipal hospitals, has a room where the temperature can be forced to provide for certain classes of cases. Wards assigned specifically to children are inadequate in capacity in all of our municipal general hospitals, with the exception of Bellevue. Owing to this fact it is necessary to distribute children in adult wards. In Fordham Hospital on 3 days of inspection there were in the children's ward 21, 23, and 23 children respectively. On the same days there were in the whole hospital 39, 50, and 36 children, respectively. The capacity of the children's ward in City Hospital is 16 beds. On 3 days of inspection there were in the hospital 71, 72, and 65 children, respectively. (Page 414.)

3. It might naturally be expected that Fordham Hospital, serving the open residence districts of The Bronx, would care for a larger proportion of medical cases than surgical. On the contrary, 56 per cent. of its cases were surgical, whereas but 27 per cent. of the total children's cases handled by Bellevue were surgical cases. In Gouverneur Hospital, located in a district where the pressure upon life is great, but 45 per cent. of the cases were surgical. (Page 415.)

4. The average stay of long term medical cases was 17 days in Bellevue; 13 days in Harlem Hospital; and 16 days in each of Fordham and Gouverneur Hospitals. The acute medical cases also remained a shorter time in Harlem Hospital than in the allied hospitals. In contrast to these periods of stay, in Metropolitan Hospital, on Blackwell's Island, acute medical cases remained on an average 35 days, while its long term cases remained 91

days. In City Hospital the average length of stay for acute cases was 27 days, and for long term cases 49 days. (Page 415.)

5. The Bellevue Hospitals seem able to get rid of infectious cases in a much shorter time than the hospitals on Blackwell's Island. The average length of stay for these cases was: in Fordham 7 days, in Harlem Hospital 9 days, and in Bellevue 9 days; whereas, in Metropolitan Hospital they remained 57 days, and in City Hospital 54 days. (Pages 415 and 416.)

6. The detention rooms in all of the hospitals, with the exception of Bellevue, are very inadequate. Harlem Hospital has one room, with an allowance of 273 cubic feet of air per child. It is lighted by a ground glass window, and opens on a corridor where the ambulance cases are received. Gouverneur Hospital's single detention room is but a short distance from, and opens on, the same corridor as the isolation room. At Fordham the nurses and many of the visitors pass through the main ward to reach the detention ward. In the detention ward at Harlem Hospital, on a day of inspection, there were cases of appendicitis, amputation, pneumonia, tuberculosis, and normal children. Similar conditions were found in some of the other hospitals. (Page 417.)

7. The children's ward in each of the hospitals, owing to the lack of detention rooms, is frequently quarantined. This occurred three times during the winter of 1913 at Gouverneur Hospital. One child in Metropolitan Hospital, while staying at the hospital 7 months and 10 days, had whooping-cough, measles, pneumonia, abscess, and possibly erysipelas. Cross infection is frequent, and in some of the hospitals sick children are obliged to look upon the suffering and death agonies of other children. (Page 418.)

8. Not a few normal children are found in the hospitals. This is more especially true in the hospitals on Blackwell's Island. (Page 419.)

9. It is a noteworthy fact that Bellevue, with a high class children's service, cares for children from all over the City, whereas each of the other hospitals seems to serve only its own ambulance district, which is a restricted area. (Page 422.)

B. Conclusions:

1. The inadequate number of nurses provided for the care of children is not due so much to the failure of the hospital authorities to recognize the need, but rather to lack of institutional appropriations.

2. The inadequacy of wards for the care of children in connection with our municipal hospitals is more largely due to the fact that at the time the hospitals were built the need for specialized care for children was not so well recognized as at the present

time. Reasonably acceptable accommodations have been provided at Bellevue, and also in a new pavilion just completed at Kings County Hospital. The authorities have been slow to recognize the need in the other hospitals, and have not put forward sufficient effort to induce the City to appropriate funds for proper accommodation.

3. There seems to be no adequate explanation of the fact that Fordham Hospital, located in a sparsely settled residential district, has a larger percentage of surgical cases than any of the other municipal hospitals in the Department of Bellevue and Allied Hospitals.

4. The fact that the average stay of medical cases is materially shorter in the allied hospitals of the Bellevue Department than in Bellevue proper seems to indicate that the services in the allied hospitals are inadequate, overcrowded, and that the hospitals are obliged to discharge the children without adequate treatment. The excessively long stay of children in the hospitals on Blackwell's Island is not due to better treatment of the children, since the facilities in these hospitals are much poorer than in Bellevue and Allied Hospitals, but it is due rather to admitting many normal children, and retaining many who have been cured and who should have been discharged.

5. The length of stay of infectious cases in the different hospitals should not vary materially, and the contrast of an average stay of 57 days in Metropolitan Hospital, with 9 days in Bellevue and Harlem Hospitals, seems to indicate a failure on the part of Metropolitan Hospital to properly reëxamine and discharge patients on the termination of their illnesses.

6. The detention rooms in all of the hospitals, with the exception of Bellevue, are very inadequate, and it will be impossible to entirely avoid cross infections so long as it is impracticable to detain children in these rooms a sufficient length of time to allow a possible contagion to develop. With the lack of detention facilities in most of our municipal hospitals, a child entering a hospital is in serious danger of contracting diseases other than that which causes it to enter the hospital.

7. Inasmuch as it seems conclusive that mothers will take their children long distances to a children's service in which they have confidence, it is of great importance that the character of the children's services in connection with all of our municipal hospitals be raised to a higher standard as rapidly as possible. The willingness of the mother to take her child to a distant part of the City in order to reach a children's service in which she has confidence makes it possible to centralize some of the children's services, rather than to attempt to develop a complete service at each of the smaller hospitals.

C. Recommendations:

1. A children's service complete in all particulars and equipped to properly care for any type of children's ailment should be provided, one in Manhattan and one in Brooklyn. The proper location of such a complete service in Manhattan is at Bellevue Hospital, where adequate space can be provided and the attendance of the highest grade of physicians secured. In Brooklyn, such a complete service should be located at Kings County Hospital. Such a service is, in a large measure, provided for at the present time at Kings County Hospital by the erection of a new pavilion devoted exclusively to children, which was opened after October 1, 1913.

2. The smaller hospitals, both in the Department of Bellevue and Allied Hospitals and in the Department of Public Charities, should provide services adequate for the general run of acute cases, both surgical and medical. Provision should not be made, however, for the exceptional case which requires special apparatus, facilities, or treatment. Such cases should be sent in Manhattan to Bellevue, and in Brooklyn to Kings County Hospital; nor should provision be made in these hospitals for the long term cases.

3. The pressure upon the children's services in each of the subsidiary hospitals of the Bellevue Department indicates that additional beds are needed. This pressure is most noticeable in connection with Gouverneur and Harlem Hospitals, and, as soon as possible, relief should be secured by the construction of at least one additional ward in each of these hospitals. The additional facilities needed in connection with the number of beds at present provided may be indicated as follows:

Gouverneur Hospital

At present Gouverneur Hospital has 10 beds in one ward used for detention. These beds, with others added, should be placed in smaller wards somewhat as follows: 4 wards of 1 bed each; 3 wards of 2 beds each; 2 wards of 3 beds each. If this number of beds is not sufficient for adequate detention, the least suspicious cases, after having been detained for a reasonable length of time, can be placed in the main ward, separated from other patients by screens. At present the hospital has one isolation ward, with 3 beds. It is important that these 3 beds be placed either in separate rooms or in proper cubicles. At the present time the cribs for newborn babies are in the maternity ward. It would be highly advisable to provide a small ward for such cribs.

The hospital has no recovery and dressing room for the children's service. It would seem important that one recovery and one dressing room be provided in connection with the surgical ward. A high temperature room should be provided unless the policy is adopted of transferring all cases needing such care to Bellevue.

There is no separate ward space for tonsil and adenoid cases. It would seem advisable to provide a ward for such a purpose, that could be used for cases operated on in both the hospital and in the Out-Patient Department. As soon as room can be provided the surgical and medical cases should be separated. At the present time the up-patient children are fed in the diet kitchen. It is desirable that they have a separate dining room, both for medical and surgical cases, if such can be provided.

A paid resident in charge of the children, giving continuous service, is needed at Gouverneur Hospital. It is recommended that one be employed at the rate of $600 per year.

It is recommended that a salary sufficient to retain a nurse specially trained in the care of children be provided.

Harlem Hospital

The lack of detention, isolation, and other auxiliary rooms will be largely met by the reconstruction which is at present being planned, and for which appropriation has been made.

Fordham Hospital

Fordham Hospital has sufficient bed capacity for children. The 42 beds it now maintains, however, should be separated into a medical and a surgical ward. At the present time it has 20 beds in one detention room. This space should be subdivided by screens to make smaller ward areas.

A recovery and dressing room is needed each for the surgical and medical divisions. A high temperature room should be provided, unless the policy is adopted of transferring cases needing such care to Bellevue Hospital. No special room is provided for the use of tonsil and adenoid cases. A separate ward for such cases is needed. The convalescent children have no space except on the verandas. A room is needed for such convalescing children.

It is recommended that a paid resident in charge of the children be provided on the same basis as is recommended in connection with Gouverneur Hospital.

A salary sufficient to secure and retain a nurse thoroughly trained in the care of children should be provided.

While it is impracticable at the present time to secure all of the above recommended rooms in connection with Gouverneur and Fordham Hospitals, a portion of these rooms can be secured by erecting partitions in the space already provided. Other rooms must necessarily wait until the buildings at these hospitals are enlarged and extended, but the needs of the children's service should be constantly borne in mind and these facilities provided at the earliest possible date.

4. Owing to the pressure upon the existing children's services it is impossible to keep children having long term ailments a sufficient length of time, and inasmuch as all of the hospitals in Manhattan are located in crowded sections, without surrounding space or lawns, they afford inadequate provision for the treatment of convalescent cases. It would seem highly advisable to erect a children's hospital devoted largely to the care of long term cases, and for convalescent children. Such a hospital should be erected where there is abundant space surrounding it, mainly devoted to lawns and play spaces for children.

It is recommended that a long term children's hospital be constructed on Blackwell's Island, the central portion of such hospital to be located near the southern boundary of the plot occupied by the City Home, and to develop to the south; the hospital to be so laid out that it may ultimately accommodate 1,000 children.

5. Owing to the inaccessibility of Randall's Island it is recommended that the sick children (those not feeble-minded) be removed from Randall's Island and placed in a long term children's hospital in case one should be erected on Blackwell's Island.

ARGUMENTS IN SUPPORT OF RECOMMENDATIONS

General Statement

It has been the endeavor to secure the opinion of some of the leading children's specialists, both in New York City and elsewhere, with regard to the best hospital system for children. These specialists were asked which, in their opinion, is the more desirable: a special children's hospital wherein all classes of cases would be treated, or children's services in connection with existing general hospitals. The general consensus of opinion was that children would be better cared for in services connected with general hospitals than in special children's hospitals having no connection with a general hospital. On the other hand, it was their opinion that long-term cases, especially those needing outdoor treatment, would be better cared for in a hospital located either in the country, or in a place where abundant space was available around the hospital. It was their opinion, moreover, that a complete children's service for acute cases could not readily be maintained except in connection with a large general hospital, and that small hospitals should not endeavor to maintain a service except for the general run of acute cases.

The recommendations in this Report have followed, so far as practicable, the opinions of these specialists.

(1 & 2) Complete Children's Services at Bellevue and Kings County Hospitals

According to the opinion of the children's specialists, as stated above, there should be, in some convenient location, a complete service for children where all cases needing exceptional treatment and provision can be cared for. New York City is probably large enough to require two such complete services, and the most appropriate place for these, as has been recommended, is at Bellevue Hospital and at Kings County Hospital. Each of these hospitals serves a large territory. The children's services in these hospitals should be made complete in every particular, so that exceptional cases of whatever nature may here receive the best treatment according to present-day knowledge. Having provided these two complete services, it would seem inadvisable to provide equipment in subsidiary hospitals for other than the common run of acute cases. According to this plan, in Brooklyn, the Cumberland Street, Coney Island, Greenpoint, and Bradford Street Hospitals would have a limited provision for the care of children, and would transfer to Kings County Hospital all cases requiring special facilities or skill in handling. Likewise, in Manhattan and The Bronx, Gouverneur, Harlem, and Fordham Hospitals would transfer acute cases of a special character to Bellevue. By this method all classes of cases could receive adequate care.

(3) Advisable Changes in Provision for Children's Services at Gouverneur, Harlem, and Fordham Hospitals

The only safeguard against the spread of contagion in children's wards is the detention, for a reasonable length of time, of in-coming cases. Hospitals that are not provided with suitable detention rooms are not infre-

quently obliged to quarantine children's wards, thus materially limiting the service they can render, and also jeopardizing the lives of children in the wards. It is of prime importance, therefore, that each hospital should have an adequate number of detention rooms, containing one or a few beds, wherein all in-coming children may be placed for a few days to await development of any contagious diseases with which they may possibly be infected. Since Bellevue Hospital became equipped with a reasonable number of detention rooms the spread of contagious diseases in the wards has been rare.

The Children's Service at Bellevue has been greatly improved of recent years, due largely to the fact that a paid children's specialist has been employed to give continuous service. A rotating service does not secure satisfactory results with adults, and much less so with children. Sick children need to be under constant supervision, and such supervision is not secured when attending physicians rotate in service.

It has been the custom heretofore to rotate nurses through the children's service, as through other services, in order that they may receive a rounded training in a variety of services. By this method, a head nurse with no knowledge of the care of children has frequently been placed in charge of the children's service. It is highly advisable that this practice should be discontinued, and that a nurse be placed in charge of the children's service who would render continuous and abiding service, and such rotating of nurses as may seem necessary or advisable take place beneath the head nurse. Continuous service in connection with the nursing of children is even more necessary and advisable than in connection with medical attendance.

(4) A Long Term Children's Hospital on Blackwell's Island

As previously stated, it seems to be the consensus of opinion of children's specialists that it is advisable to have a long term children's hospital to which long term cases may be transferred from acute hospitals. In order to insure the attendance of high grade children's specialists a large number of children must be gathered together in such a hospital. A limited service, for instance, in connection with Metropolitan and City Hospitals, would probably not attract the grade of children's specialists desired. To induce Bellevue and its Allied Hospitals to transfer children's cases to another hospital the latter must be of the highest grade and provide the best care obtainable. Such grade of service, it is believed, is not likely to be secured except in connection with a hospital specially designed for the care of children, and which would attract the best of specialists because of the large number of children treated.

Since large factors in the treatment of long term cases are fresh air and sunshine, it is highly advisable that such a hospital should be placed on one of the islands in the East River, where there is an abundance of air and sunshine.

Inasmuch as a children's hospital already exists on Randall's Island, accommodating about 500 children, it would seem advisable to perfect and enlarge it for such a hospital were there not strong reasons for locating it elsewhere. It is true that Randall's Island has about 84 acres which can be devoted to this purpose, and that it is well covered with trees and otherwise attractive, and also that it would be more economical to enlarge this existing hospital than to construct a new one, either on Randall's Island or elsewhere, but the buildings at present used as the children's hospital

are old, and would need to be renewed in a comparatively few years, so that if nearly the whole hospital plant would have to be reconstructed it could be done as cheaply elsewhere as on Randall's Island. Since such reconstruction is probably advisable and necessary the problem resolves itself into a question of location, with the cost of reconstruction eliminated.

Though Randall's Island has the advantage of an abundance of ground, it has the disadvantage of isolation. It is not connected with the mainland by a bridge, and probably never will, owing to the great expense of the construction of such a connection. It will, therefore, be necessary to continue ferry service to the Island as the only means of communication. Because of this fact, Randall's Island will always be more or less inaccessible. It will be practically impossible to get an attending physician to the Island on an emergency call, which fact will result in leaving very sick children largely in the care of internes. This situation has not been serious in the past because of the class of children's cases cared for at the institution on Randall's Island. Few of the cases have ailments which develop acute conditions. If, however, the system were adopted of transferring from Bellevue and Allied Hospitals all cases likely to remain over possibly 35 days, it would result in a different class of cases going to the long term hospital—cases which not infrequently would require the immediate attention of the attending physician. It is doubtful whether such attendance could be secured on Randall's Island, and for that reason probably Bellevue and its Allied Hospitals could not be induced to send this class of cases to a children's hospital thus isolated.

It is the intention of the City ultimately to remove the Penitentiary and the Workhouse from Blackwell's Island. For certain reasons it would also seem desirable to remove the City Home from Blackwell's Island. In case these three institutions were removed 80 acres of land would be left available for the purpose of a hospital, a space about equal to that on Randall's Island. This space, though not as well distributed as on Randall's Island, nevertheless would give abundant play space for children were it occupied by a children's hospital.

The chief advantage of Blackwell's Island as a site for a hospital is that it is crossed by a bridge connecting both Manhattan and Queens. Elevator connection could be made between the island and the bridge at a comparatively small expense, and in a short space of time. After such installation the Island would be nearly as accessible to attending physicians and the friends of patients as the mainland. A hospital thus located could secure the services of physicians and surgeons from either, or both, City and Metropolitan Hospitals, which would give such a children's hospital practically the same advantages of service as though it were connected directly with a general hospital, and were on the mainland.

Within a comparatively few years the Queens territory will probably be as densely populated as The Bronx is to-day. When this development takes place it will be necessary to furnish hospital facilities to the inhabitants of that territory. Blackwell's Island is very accessible to that territory by way of the Queensboro Bridge, and it would probably be unnecessary to build any hospitals in that district for many years to come if Blackwell's Island were made accessible by means of elevators to the bridge. Thus, material economy would be secured by utilizing the hospitals on Blackwell's Island to serve the Queens territory.

Mothers are loath to send children to a hospital under any circumstances, and more especially to a hospital that is inaccessible, where they

find it difficult to make frequent visits. For this reason it is probable that a children's hospital on Randall's Island would never serve its full purpose, whereas, were it located on Blackwell's Island, mothers could reach it with about the same ease as though it were on the mainland, and, owing to this fact, would probably much more readily allow their children to go to a hospital thus located.

It would seem practicable and expedient to start a children's hospital near the southerly boundary line of the plot occupied by the City Home and locate additional buildings to the southward, where there is a large tract of open territory. As such a hospital developed it would probably be found feasible and advisable to remove the City Home from the Island, thus making available the space, and possibly some of the buildings, which it now occupies. After the new hospital were sufficiently developed, all of the hospital children from Randall's Island could be transferred to it.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

PHYSICAL EXAMINATION AND EMPLOYMENT OF DEPENDENTS IN CITY HOMES (ALMSHOUSES)

A. Summary of Findings:

1. Aside from those occupied in the care of the institution, less than 50 inmates are employed at industrial work in the Manhattan City Home. These are occupied in making brooms, mattresses, clothing, and repairing shoes. In the Brooklyn Home about 75 are so employed and do the same things as are done in the Manhattan Home. At Farm Colony, in addition to those employed on the farm and in connection with the institution, about 75 at times are employed in mat making and sewing. (Page 437.)

2. Inmates admitted to the City Homes are examined physically only to the extent necessary to determine whether or not they should enter an almshouse or hospital. (Page 437.)

3. Whether or not an inmate should be put to work, and the nature of such work, is dependent upon the judgment of a lay superintendent. (Page 438.)

4. No consistent method of determining the degree of health or sickness of inmates exists. (Page 438.)

5. A thorough physical examination was made of over 500 inmates at the Manhattan Home, under the direction of Dr. L. L. Williams, now at the head of the United States Public Health Service at Ellis Island. The results of said examination may be summarized as follows:

Of the male inmates, 4.3 per cent. were able to do heavy farm work; 8.2 per cent. were in condition to do heavy mechanical work; 3.7 per cent. were able to do light farm work; 7.2 per cent. were able to do domestic work; 6 per cent. could do non-sedentary light mechanical work; and 29 per cent. were able to perform light mechanical work of a sedentary nature. Of the total, 60 per cent. were able to do work of some form. Of the remaining 40 per cent., 19 per cent. were so crippled and infirm as to be unable to do any work, and the remaining 21 per cent. were in need of daily medical attention and should have been assigned to hospital wards. (Page 441.)

6. It may be estimated on the basis of the close physical examination made under the supervision of Dr. Williams that approxi-

mately 3,000 inmates should be able to do some physical work. At the present time less than 1,500 are employed. (Page 439.)

7. Full instruction as to the method to be employed in making physical examination of inmates is set forth in the Report. (Pages 444 to 450.)

8. An examination of certain almshouses in other states was made to determine the proportion of inmates employed. In the City almshouse in St. Louis, out of 675 inmates, 500 were daily employed for an average of 5 hours per day. They performed all the laundry work of the institution, did all the sewing, made all the clothing and shoes, made soap for their own and other institutions, manufactured mattresses for their own and other institutions, constructed a large portion of the furniture used in the Almshouse, and bound all the books in the library of the institution. In no almshouse visited did the inmates appear more contented and happy than in this. (Page 451.)

Of the 725 male inmates in the almshouse in Philadelphia, 600 were daily employed, chiefly in the care of their own and several other institutions associated with it. In addition to such work, they made shoes, wove cloth, made clothing, mattresses, brooms, and did printing. (Page 451.)

9. The value of farm products at Farm Colony for the year 1911 averaged $168 per acre. Nearly the entire acreage was devoted to the raising of vegetables. The State Farms in Massachusetts are in the main devoted to general farming. The farm of the State Hospital in Worcester in 1911 produced farm products to the value of $341 per acre. Medfield Farm produced farm products to the value of $524 per acre. The products of Foxborough Farm were valued at $353 per acre. The farm connected with Manhattan State Hospital on Ward's Island, New York City, is devoted entirely to garden truck. On its 63 acres in 1911 $25,870 worth of vegetables were produced. Farm Colony, devoted to like crops, produced but $8,051 worth of products, if estimated at the same prices used by Manhattan State Hospital. (Pages 452, 453 and 454.)

B. Conclusions:

1. Inasmuch as the physical examination of inmates made by this Committee has shown that about 60 per cent. of the inmate population are able to do some form of work, it seems highly desirable, both for the welfare of the inmates and for the economy of operation of the institutions, that such of the inmates in this class as are not now employed should be provided with work of a character suited to their condition.

2. Farm Colony is not now successfully operated. It could produce, if properly managed, two or three times the value of products which it is now producing. There are at the Colony about 750 men and 250 women. The average number of patients at

Manhattan State Hospital used for the cultivation of its farm is about 80. It seems highly improbable that out of the 750 men, supposed to be sent to Farm Colony because they are relatively able-bodied, there could not be selected a sufficient number to properly cultivate 70 acres of land, since Manhattan State Hospital is able to cultivate its 63 acres with 80 men.

3. The investigation has shown that quite a large proportion of the inmates of Farm Colony are crippled, infirm, and senile, and are not of the class that for a number of years after the opening of Farm Colony were sent there. It is quite probable that a certain proportion of the relatively able-bodied men and women are occupied in caring for those that are less able. Inasmuch as the farm is less productive now than it was when it had much fewer inmates and less paid help, it seems probable that the policy of sending the infirm to Farm Colony has not only lessened the value of farm products, but has in quite a measure destroyed the primary and fundamental conception of Farm Colony as a place wherein to occupy the man discouraged, out of work, and partially incapacitated.

C. Recommendations:

1. A medical officer should be provided, who would make detailed physical examination of all inmates admitted to the almshouses. (This recommendation is set forth in detail, beginning on page 65.) Subsequent to the admission of inmates, a medical officer should periodically inspect the inmates to ascertain their physical condition and the progress of any disease with which they may be afflicted. Such examination should determine whether or not they are being employed at suitable work, and for the number of hours which their degree of strength warrants.

2. Install at once at the City Homes on Blackwell's Island and in Brooklyn sufficient devices and machinery to employ 25 per cent. of those able to work; such machinery to be of a simple form and requiring little manual labor. If, after the operation of such machinery, the plan of employing the inmates seems feasible and capable of extension, install a sufficient amount of machinery and devices to employ all those in the institutions not actually in the hospital or neurological division or employed in connection with the operation of the institution.

3. If after investigation it is found suitable, devote the low lands of Farm Colony to the raising of willow, from which baskets and other willow containers and furniture may be manufactured, and occupy a certain proportion of the men during the winter in the manufacture of these willow articles.

Install machinery and devices of a suitable character to employ the relatively able-bodied men at Farm Colony during the winter months.

4. Employ an instructor in industrial work for each of the City Homes, at a salary of from $900 to $1,200 per year.

5. Ask the State Department of Agriculture to inspect the farm at Farm Colony and make suggestions as to methods which will secure the maximum amount of products. The right to make such examinations on the part of the State Department of Agriculture is provided for in Chapter 460, Laws of 1913.

6. Remove from Farm Colony all crippled, infirm, and senile inmates, and erect no more dormitories at the Colony. The capacity at present is larger than is needed to accommodate all of the relatively able-bodied men not required in connection with the care and maintenance of the City Homes on Blackwell's Island and in Brooklyn.

7. Provide only a temporary detention room for the insane at Farm Colony, and transfer all alleged insane for examination and observation to Bellevue or Kings County Hospitals.

ARGUMENTS IN SUPPORT OF RECOMMENDATIONS

(1) Physical Examination of Inmates

Arguments in support of the advisability of making such examination are set forth on page 437 and following pages.

(2) Installation of Machinery

That not a large proportion of the inmates are at present employed is set forth on subsequent pages, and that some large almshouses employ a much larger percentage than do the almshouses in New York City is also shown. The physical examination made by the Committee has clearly demonstrated that about 60 per cent. of the inmates are able to work. But, as many of these inmates would be obliged to do sedentary work, and many also to perform only the lightest kind of labor, and as it would be an experiment to install machinery and devices for the employment of those not already employed in the care of the institutions, it would seem advisable to employ only inexpensive machinery; such as machines for knitting socks, mittens, sweaters, etc.; devices used in connection with braiding rugs; and such other machinery and devices as can be used by those having comparatively little strength. It would also seem advisable to obtain at the present time only enough to employ not more than 25 per cent. of those unemployed. After such machinery has been installed, and if the plan seems to work satisfactorily, additional machinery can be secured.

(3) Raising of Willow for Furniture and Containers

Willow is successfully raised by the State Hospital at Crownsville, Md. It seems probable that the low land at Farm Colony is suitable for willow culture. The making of willow furniture and containers does not require great skill, and it is a class of work that would be very suitable to such an institution as Farm Colony. If the willow could be raised at the Colony, the men could be occupied, both in cultivating, gathering and preparing the willow, and in manufacturing it.

The men who are employed upon the farm in the summer have little to do in the winter unless special work is provided for them. A portion of them can be occupied in various constructional work about the institution, but a large number will remain comparatively idle unless special effort is put forward to provide a kind of labor which they can readily perform. It would seem advisable, therefore, that machinery be installed with which these men may work during the winter season. Inasmuch as these men are relatively able-bodied, the product to be manufactured should be of a kind requiring more physical labor than the products designed to be manufactured at the Homes in Manhattan and Brooklyn.

(4) Instructor in Industrial Work

In order to carry on industrial work successfully in an almshouse it is necessary to have one or more instructors, who are not only able to teach the inmates how to operate the machines and devices, but also to supervise

them and to see that they are kept at work. It would serve little purpose to install machinery to be operated by the inmates unless some competent person be employed to instruct them how to use it. It is probable that a salary of $1,200 would be sufficient to secure the services of a man trained to do such work. If the things to be manufactured are selected with care, and only those things manufactured which are needed in City institutions or departments, the product of the labor of the inmates should much more than offset the salary of the instructor, the interest on the cost, and the upkeep, of the machinery.

(5) Examination of the Farm at Farm Colony by the State Department of Agriculture

Chapter 460 of the Laws of 1913 empowers the Department of Agriculture to make examination of almshouse farms, and to offer suggestions with regard to their operation. It would seem highly advisable that New York City should avail itself of the advice and services of the Department of Agriculture.

(6) Removal of Crippled, Infirm, and Senile from Farm Colony

As shown on page 453, the value of products produced on the farm at Farm Colony has decreased from $68.52 per inmate in 1904, to $16.74 in 1911. In 1904 there were 11 employees connected with the institution and in 1911 there were 58. Although the number of employees at the institution had increased fivefold, the gross value of farm products was not increased, and the value per inmate decreased over fourfold. This situation was probably, in a measure, due to the fact that a large number of crippled, infirm, and senile have been sent to the institution. (See detailed statement on page 442.) The number of inmates in 1904 was 185, and in 1911, 703. Although the number of inmates increased fourfold between these years, the increase has been so largely of the unproductive class that the Colony farm has suffered rather than benefited by the additional number.

The presence of the crippled, infirm, and senile at the Colony not only hinders the work of the farm, but places an additional burden upon the institution in many ways. This burden requires time and attention on the part of the Superintendent, which otherwise could and should be devoted to the proper operation of the farm. These inmates can be cared for as cheaply on Blackwell's Island, or in Brooklyn, as at Farm Colony. The argument has been put forward that, inasmuch as dormitory accommodations exist at the Colony they should be used, and for that reason this class of inmates has been transferred from the other two Homes. It has also been stated that the Manhattan Home was greatly overcrowded, and that it has been necessary to transfer many patients to the Colony. The fact is that the overcrowding of the Manhattan Home during the years 1911 and 1912 was due in quite a measure to the transfer of chronic patients from Metropolitan and City Hospitals to the Home. These patients were transferred for the purpose of making room for acute cases at these hospitals. In order, therefore, to increase the acute service in Metropolitan and City Hospitals, Farm Colony has been made to suffer by transferring to it a class of patients not designed to be cared for in that institution. But if additional accommodation is needed for inmates, it would seem advisable to provide for it in connection with the Manhattan or Brooklyn Homes, rather than at Farm Colony. It is highly improbable, however, that additional bed

capacity will be needed in these institutions if the Bureaus of admission to the almshouses rigorously examine all applicants and exclude those not entitled to support by the City. According to that part of this Report entitled "Admissions to City Homes," fully 20 per cent. of those admitted seem not to be entitled to support by the City, so that a careful examination of all applicants, and the exclusion of those not entitled to support, will probably provide all the additional bed capacity needed in the near future.

(7) Removal of Insane from Farm Colony

High class psychopathic services are provided at Bellevue and Kings County Hospitals, where patients may receive careful examination by trained and competent alienists. No such service exists at Farm Colony, and the small number of insane on Staten Island would not warrant the creation of such. It seems unjust to the alleged insane on Staten Island not to give them the same high class services accorded to a like class of patients in Manhattan and Brooklyn. The Commissioner of Charities has the power to transfer the patients at the Colony to either of the aforesaid institutions for examination, and for the welfare of such patients it would seem highly advisable that such action should be taken. Should such a system be adopted, an alleged insane person would be kept at the Colony but a night or a day, and immediately transferred to Bellevue or Kings County Hospital. By this method fewer attendants would be required at the Colony; the alleged insane would be much better cared for; and the expense of operation of the Colony would be reduced.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

THE OUT-PATIENT DEPARTMENT OF GOUVERNEUR HOSPITAL

A. Summary of Findings:

1. The first 1,000 cases that came to Gouverneur Out-Patient Department during the first two weeks of January, 1913, were taken in order from the registers of the Children's, General Medical, Gynecological, and Nose, Throat and Ear Clinics. Every one of these patients was visited at the address given in the books and information gathered regarding the home and financial conditions, number of visits to Gouverneur Out-Patient Department, result of treatment, and subsequent disposition of the case. Several days, at intervals during a period covering three months, were spent in observing the conditions in the dispensary itself. (Page 459.)

2. Many patients are admitted to a clinic room at the same time, and when the room is thus crowded the physician in many instances makes no attempt to examine the patients, but only prescribes some medication on the basis of their reply to his question: "What's the matter with you?" On March 15, 1913, an investigator saw 162 patients treated by two physicians in the female medical clinic in one hour and a half. In the room used as a children's clinic (149 sq. ft.) another investigator counted 36 patients at one time. (Page 460.)

Of the 63 doctors and physicians comprising the staff of Gouverneur Out-Patient Department, 46 per cent. have their private offices located in the neighborhood of Gouverneur. Their private patients are drawn, in the main, from the same district as the dispensary patients.

3. In 14.1 per cent. of the cases the patients, when questioned in their homes, stated that no physical examination was given them. The greatest percentage was in the General Medical Clinic, where 22.6 per cent. of the cases had not been examined; in the Gynecological Clinic 16.3 per cent. of the patients had not been examined. (Pages 464, 465, and 466.)

In 31.3 per cent. of the cases visited the patients, dissatisfied with the treatment at Gouverneur, had gone to other dispensaries or to private physicians. In 6.8 per cent. of these cases the patients stated that the private physician found the disease to be different

from the diagnosis of the Gouverneur doctors. These alleged wrong diagnoses involved cases of pneumonia, scarlet fever, and diphtheria. (Page 466.)

4. Cases of contagious and communicable diseases mingle with the other patients in the waiting room for long periods of time before examination, and, at times, after they have been examined. They are dismissed from the clinic rooms with the direction to stay away from the dispensary and to "go to a doctor." Of those investigated, it was found that in the majority of cases the patients were unable to engage the service of a private physician and had remained ill in the home without any medical attention, with resulting danger of contagion to the other members of the family and the tenement. (Page 461.)

5. The average number of visits per patient at the Gouverneur Out-Patient Department was compared with the St. Bartholomew Clinic of New York, as follows:

Clinics	Average Number of Visits per Patient	
	Gouverneur	St. Bartholomew
General Medical	2.8	3.7
Gynecological	3.7	6.8
General Surgical	2.3	5.3
Genito-urinary	6.7	5.5
Rectal	...	14.3
Eye	2.3	3.3
Ear	...	6.7
Nose and Throat	*(1.7)	4.2

* Ear, Nose and Throat are in one clinic in Gouverneur Hospital.

(Page 463.)

6. In all the clinics, except the Tuberculosis and Gynecological, the only data entered are the name, age, address, and diagnosis, and when a very busy period occurs even these items are neglected. (Page 462.)

7. In the four clinics investigated, 52.6 per cent. of the patients did not return after the first visit. Of those who did not return, 44.5 per cent. stated that they had been benefited or cured by the treatment, and 55.5 per cent. stated that they had not been benefited. Of the 47.4 per cent. who had made two or more visits, 13.4 per cent. stated that they had been cured by the treatment; 30.6 per cent. were benefited; while 56 per cent. believed themselves not to have been benefited.

In the different clinics the percentage of cases that had not been benefited by the treatment after repeated visits, according to statements made by patients, ranged from 41.7 per cent. in the Nose, Throat and Ear Clinics, to 88.5 per cent. in the Gynecological Clinic. (Page 466.)

B. Conclusions:

1. It is evident that the treatment given in the Out-Patient Department of Gouverneur Hospital is far from satisfactory. This, no doubt, is owing in quite a measure to the cramped quarters in which the Out-Patient Department is operated, but with the new building which is now being planned it is hoped to obviate many of the shortcomings herein noted.

2. When the new building is put into use it will be advisable to entirely reorganize the Out-Patient Department. New forms of records are needed; more attendants and nurses; a social service department should be organized; and a larger proportion of attending physicians should be secured from districts not served by the Out-Patient Department.

3. It will be desirable to give the Out-Patient Department a better coördination and connection with the hospital, so that there may be a freer interchange of patients between the two departments.

C. Recommendations:

1. A new building is to be built for the use of the Out-Patient Department of Gouverneur Hospital, plans for which are now being drawn, and this new building will correct some of the bad conditions referred to in this Report. Before entering into this new building when completed the Out-Patient Department should have a thorough reorganization.

2. Recommendations for the organization of an Out-Patient Department are incorporated in a part of this Report entitled "Suggestions for the Organization of a Public Out-Patient Department" (page 469); and in so far as such general recommendations are applicable they may be adopted in the reorganization plans of Gouverneur Out-Patient Department.

STATEMENT

WITH REGARD TO

SUGGESTIONS FOR THE ORGANIZATION OF A PUBLIC OUT-PATIENT DEPARTMENT

The above indicated memorandum cannot readily be summarized, for the entire memorandum is primarily a recommendation.

The fundamental purpose of the memorandum is to emphasize the importance of the out-patient department; to show the number and kinds of rooms that should be provided; and the character of organization and administrative methods that should prevail.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS,

WITH REGARD TO

SICKNESS IN THE HOME AND PROPOSED HEALTH CENTER

A. Summary of Findings:

1. The Committee made inquiry as to the amount of sickness in the home by two methods. First, the number of deaths resulting from various diseases was ascertained from the records of the Health Department, and the amount of sickness in the home was estimated by multiplying these ascertained deaths by ratios established by leading medical authorities—for purposes of brief description this may be designated as method No. 1. Second, limited and prescribed districts were selected, one in the vicinity of Rivington and Eldridge Streets, on the East Side, and the other in the vicinity of Ninth Avenue and 36th Street, on the West Side, and by a family to family canvass, information was gained as to the amount and character of sickness and the treatment afforded—this may be termed method No. 2. (Page 522.)

2. By method No. 1 it was estimated that about 89 per cent. of sickness was cared for in the homes of the East Side. Even in such serious ailments as typhoid fever, about 70 per cent. of the deaths took place in the homes; 84 per cent. from diphtheria; and 85 per cent. from pneumonia. By method No. 2 it was estimated that 91.4 per cent. of the sickness was cared for at home. (Pages 523 and 529.)

3. By method No. 1 it was estimated that in the population of 621,339 on the lower East Side, during the year 1910, there were 3,600,000 days of sickness cared for in the homes, as compared with 370,000 days of sickness cared for in hospitals. In the population of the West Side district, which was about 140,000, there was a total of about 1,427,000 days of sickness in the homes, and but 116,700 days in hospitals. (Pages 523 and 526.)

4. About 10.6 per cent. of the sickness on the East Side was taken to hospitals, whereas 32.3 per cent. was cared for in dispensaries. Of those who visited dispensaries, 29 per cent. made but one visit (page 532). The records of Gouverneur Dispensary indicate that over 50 per cent. make but one visit. (Page 468.)

5. Of all deaths in the East Side district, 43 per cent. were of children under 5 years of age. There were 39,000 cases of diar-

rhœal diseases among children, of which but 4,750 were cared for in hospitals. (Page 525.)

B. Conclusions:

1. A very large proportion of all sickness is cared for in the home, and this will continue so because of various considerations. If the City is to assume the responsibility of caring for sickness it is imperative that there should be some means of securing fuller knowledge of home conditions which produce sickness, especially in so far as such home conditions may be of a social nature and controllable by City regulations.

2. The small percentage of sickness taken to hospitals and the large number of cases of sickness which attend dispensaries but once, indicate a lack of confidence in municipal hospitals and dispensaries on the part of most of the people.

3. From the investigation of sickness in the homes it is evident that the municipal hospitals have comparatively little knowledge of the condition of the homes from which sickness comes to the hospitals or to which convalescent cases are sent.

C. Recommendations:

1. With the purpose of more adequately caring for sickness in the home, and with the purpose of curing or alleviating many of the conditions set forth in this and other sections of the Report, the Committee suggests the establishment of an experimental Health Center, which is described in detail, beginning on page 535.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

HOSPITAL HELPERS

A. Summary of Findings:

1. A large proportion of Hospital Helpers are so-called "rounders" and "periodic drunks." Many of them, however, are capable and render good service. (Page 551.)

2. The large number of changes represent, in the main, the same personnel, shifting from institution to institution. (Page 558.)

3. Raising of the yearly wage from lower to higher grades during the last four years has not increased the average length of stay. (Page 558.)

4. The eight lowest grades, from $60 to $168, show about the same percentage of discharges in each of the four years examined, although the average wage had been increased within these grades. (Page 558.)

5. The percentage of discharges in grades $180 to $264 in the Department of Bellevue is as large as the percentage of discharges in the grades $60 to $168 in the Department of Charities. The average length of stay in the corresponding grades is less in these upper grades in Bellevue than in the lower grades in the Department of Public Charities. (Page 561.)

6. The grades of Hospital Helpers and titled positions overlap. The highest grade of Hospital Helpers is $720; below this highest grade fall such titled positions as seamstress, cook, barber, tailor, etc.

7. The sleeping quarters for Hospital Helpers at Kings County Hospital, and Children's Hospitals and Schools, Randall's Island, are inadequate and undesirable in character. (Pages 565 and 566.)

8. The service building at Metropolitan Hospital is old, dilapidated, and inadequate. (Page 565.)

B. Conclusions:

1. The City has assumed the support of the indigents; and, in the absence of other institutions wherein the periodic and semi-responsible drunks can live and work, they can, to the best advantage, both to themselves and to the City, be supported as workers in the City's hospitals.

2. This class renders good service when sober, and is content to serve for a small wage.

3. When the Hospital Helper leaves the service because of drunkenness it is easy to fill his place, usually with an experienced Helper, during about eight months of the year. In the summer months there is some scarcity of help, which, however, is not a serious handicap, owing to the fact that there are fewer admissions during these months.

4. The lower grades, from $60 to $168 per year, act as a buffer to the higher grades, and when the lower grades are abolished the same character of Helpers is employed in the next higher grades, without decreasing the percentage of discharges or increasing the constancy of service.

5. Since raising wages in the lower grades has not increased the length of stay in the institutions, it is a waste of money to increase the wages of any large proportion of the Helpers serving in the lower grades, unless such increase abolishes all low grades.

6. It is the opinion of some of the officials in the hospitals that good living and sleeping quarters and good food contribute largely toward contentment of the workers, and that such conditions tend to increase the constancy of service. These opinions seem to be borne out by the fact that the average length of stay in Kings County Hospital is less than in City Hospital or Metropolitan Hospital, although the average wage is larger in Kings County Hospital than in these other hospitals, which have better accommodations for the low-paid Helpers.

C. Recommendations:

1. Let all employees receiving $480 and below be called Hospital Helpers. Let all receiving more than this amount have titled positions.

2. Retain grades $120, $180, and $240 until such time as the City shall have accommodation in its Hospital and Industrial Colony, to be established, for the class of Hospital Helpers who are subject to periodical drunkenness, and also until such time as the City can afford to pay a minimum wage of $240 for women and $300 for men.

3. Of the existing 21 grades abolish all but the following: $120; $180; $240; $300; $360; $420; $480.

4. The persons to be employed in these grades and the conditions of promotion are set forth in an accompanying Salary and Wage Schedule.

5. Provide better living and sleeping quarters for Hospital Helpers, especially at Kings County Hospital, and Children's Hospitals and Schools, Randall's Island.

STATEMENT

WITH REGARD TO

PROPOSED SALARY AND WAGE SCHEDULE FOR THE DEPARTMENT OF PUBLIC CHARITIES

No summary has been made of the memorandum bearing the above title, since it is solely the presentation of a proposed schedule. It is based largely upon the information gained in the investigation conducted in connection with the report on Hospital Helpers, which immediately precedes this.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

HANDLING OF FOOD AND FOOD WASTE

A. Summary of Findings:

Bellevue and Allied Hospitals

1. The amounts of the various kinds of food used in Bellevue and its allied hospitals were determined for the year 1912. Considerable variation was found in the amounts of like kinds of food used in the different hospitals. Of meat, Bellevue Hospital used 344.8 pounds; Harlem Hospital 372.5 pounds; Gouverneur Hospital 319.6 pounds; and Fordham Hospital 393.6 pounds per capita in the year. Fordham Hospital used 84.2 pounds of mutton per capita in the year, as compared with 44.1 pounds used by Gouverneur Hospital. Of poultry, Bellevue Hospital used 42 pounds per capita during the year, as compared with 79.5 pounds used by Harlem Hospital, and 83.4 pounds used by Fordham Hospital. The consumption of milk by Harlem Hospital was 733 pounds, whereas Fordham Hospital used but 547 pounds per capita during the year. (Page 585.)

2. The requisitions from the allied hospitals are passed upon by the Dietitian at Bellevue Hospital without a knowledge of the number for whom such food is required in these hospitals. (Page 586.)

3. The amount of food estimated for in the budget of Bellevue Hospital is determined in the accounting department, without consultation with the Dietitian. (Page 586.)

4. The requisitions for food made out by the Dietitian in Bellevue Hospital apparently are not based upon the fluctuating census of the hospitals. During the first six months of 1912 the average daily census of patients was 1,324, and the weekly issue of meat[1] was 4,671 pounds. During the second six months of the year the average daily census was 1,171, while the weekly average issue of meat was 4,733 pounds. Thus, it will be seen that more meat was used in the gross during the second half of the year, although the average census was 153 less, than during the first half of the year.

The average daily issue of meat per patient during the week ended April 28, 1912, was .48 pound, and approximately this same

[1] The term "meat," as used in this Report, includes poultry and fish.

ratio was maintained in the months of March, April, and May. Had this ratio been maintained throughout the year Bellevue Hospital would have used 217,774 pounds of meat for the patients, instead of the 244,289 pounds which were actually issued.

During the months of March, April, and May, 1912, the average census of patients in Bellevue Hospital was 1,337. During these months the average monthly issue of eggs was 9,708 dozen. During August, September, and October, when the average daily census of patients was 1,159, the average monthly issue of eggs was 9,740 dozen.

During 1912 Bellevue Hospital used 94,926 pounds of fowl. Of this, the patients used approximately 37,540 pounds. The remainder, 57,386 pounds, was used by officers and employees. The average number of employees was 1,013, and of patients, 1,243. (Pages 586 and 587.)

5. The patients in Bellevue Hospital received, on an average, about one-half pound of meat per capita per day. Had the officers and employees consumed a pound of meat per capita per day the total consumption of Bellevue Hospital for the year 1912 would have been 596,682 pounds. The actual issue was about 771,075 pounds. The meat used for officers and employees in excess of the ratio of one pound per capita per day cost approximately $20,900. (Page 587.)

6. At the request of your Committee, the amount of waste food returned from the plates in four dining rooms at Bellevue Hospital was weighed by the employees in the dining rooms during a week in the fore part of June, 1913. The waste in the staff dining room averaged 1.4 pounds per capita per day, and in the Nurses' Residence 1 pound per capita per day. The highest per capita waste in any of the dining rooms at Kings Park State Hospital, where waste is carefully guarded, was .33 pound per day. The lowest per capita waste noted in Bellevue Hospital was .42 pound per day, whereas the average per capita waste in Kings Park State Hospital was .23 pound per day. (Page 589.)

7. An employee of your Committee, during the latter part of July and the fore part of August, 1913, separated the waste returned from the plates after each meal in the staff dining room and in the dining room of the Nurses' Residence during a period of six days. As a result of this careful analysis of the waste it was found that in the staff dining room, which fed on an average about 200 daily, the total waste of meat alone was about 230 pounds. On one day 25 pounds of porterhouse steak were returned with the plates, and, at the same time, 38 pounds remained in the pantry, cooked but not served. The average daily waste of food returned from the plates in this dining room was 215 pounds.

The dining room in the Nurses' Residence serves approximately 350 persons per meal. During the six days in which the waste was segregated by an employee of your Committee the total waste of meat returned from the plates was 285 pounds. On one day 89 pounds of steak and chicken were returned, and on another day 55 pounds of Irish stew and veal were returned. The average daily waste of all foods returned from the plates was 281 pounds. (Pages 587 to 594.)

Department of Public Charities

1. According to the Storehouse records Metropolitan Hospital received 431,000 pounds of beef during the year 1911. According to the distribution records of the Dietitian, the butcher delivered to the kitchen 311,000 pounds, which indicates an unaccounted for difference of 27 per cent. (Page 595.)

2. The delivery records in Kings County Hospital were checked for the first week in January, 1912. According to the Dietitian's records the kitchen received 3,422 pounds of beef, bone, and stock. According to the delivery records of the butcher he sent to the kitchen during this same period 4,051 pounds. There seemed to have been no knowledge of the discrepancy between these two sets of records, and no attempt to reconcile them. (Page 595.)

3. In the State hospitals for the insane there is not more than 2 per cent. variation between the records of the amount received by the butcher and the amount delivered to and receipted for by the kitchens. (Page 596.)

4. The gross amount of all kinds of food used by the different hospitals in the Department of Public Charities varies markedly. Kings County Hospital used 1,376 pounds of food per capita per year, as compared with 1,649 in City Hospital, and 1,722 in Metropolitan Hospital. (Page 597.)

5. The difference in the gross amounts of food used in the different hospitals also represented a difference in the amount of food elements; viz., protein and calories. Kings County Hospital used food containing on an average 108 grams of protein per capita per day, as compared with 138 in City Hospital and 143 in Metropolitan Hospital, while Bradford Street Hospital used 162. The calories contained in the food used in Kings County Hospital amounted to 3,021; in City Hospital 3,820; in Metropolitan Hospital 3,795. (Page 597.)

6. Metropolitan and City Hospitals used more beef during the summer months, when fresh vegetables were abundant, than during the winter months, when vegetables are obtainable only in dried or canned forms. The average daily per capita consumption of beef in City Hospital in the six months ended March, 1911, was

.48 pound, and in the following six months .485 pound. In Metropolitan Hospital it was .515 pound in the winter months and .55 pound in the summer months. (Page 598.)

7. The patients in the hospitals of the Department of Public Charities received more food per capita per year than the inmates of the State insane asylums. The average consumption in five of the large State hospitals for the insane during the year 1910 was 1,236 pounds. The average issue in the hospitals of the Department of Public Charities for the year 1911 was 1,605 pounds. (Page 598.)

Department of Health

1. A marked variation was noted in the per capita amount of food used in the different hospitals of the Department of Health. Willard Parker Hospital and Kingston Avenue Hospital care largely for the same class of patients. Willard Parker Hospital used, during the year 1912, 1,655 pounds of food per capita, while Kingston Avenue Hospital used but 1,371 pounds per capita. In the amount of food supplied at Willard Parker Hospital there were 116 grams of protein per capita per day and 3,205 calories. In the food supplied at Kingston Avenue Hospital there were 87 grams of protein per capita and 2,578 calories.

The Sanatorium at Otisville, which cares exclusively for tuberculous patients, used 2,447 pounds of food per capita, whereas Riverside Hospital, which cares for both tuberculous patients and some patients of mixed contagions, used 2,207 pounds per capita. Tuberculous patients are supposed to be fed on a heavy meat diet. These patients at Otisville received 573 pounds of meat per capita during the year. The tuberculous patients at Riverside Hospital, including some cases of mixed contagion, received 464 pounds of meat per capita. (Pages 600 and 601.)

B. Conclusions:

Bellevue and Allied Hospitals

1. The difference in the amount of food used in the different hospitals of the Department of Bellevue indicates a lack of proper supervision of the distribution of food from the central storehouse to the allied hospitals. The distribution to these hospitals cannot be properly regulated without a determination of the per capita amount of each kind of food which these hospitals should receive, accompanied by a daily accounting of the amount sent to these hospitals and the amount remaining to their credit. A close supervision of this general character has not been exercised by the officers at Bellevue Hospital.

2. The failure to adjust the daily distributions of food in Bellevue Hospital to the varying number of patients and employees

has resulted in either an underfeeding in certain seasons, or overfeeding in other seasons, or a waste of food. The per capita distribution of food in the months when the census was largest was probably sufficient, judging by the gross amount distributed. This leads to the conclusion that in other portions of the year the patients were overfed, or that a portion of the food was wasted.

3. The amount of meat served to the patients in Bellevue is sufficient, but the amount served to the officers and employees is excessive and accompanied by a marked waste.

4. The waste of food in the kitchens examined seemed to be due to (a) requisitioning more than was needed; (b) the preparation of all food requisitioned without regard to the number to be served; (c) the preparation and serving of excessively large individual portions; and (d) the serving of all plates in the pantry with equal portions, irrespective of the personal tastes of those served.

5. Although gross waste has been noted in connection with the handling of food in Bellevue Hospital, the Superintendent and other officers of Bellevue are not subject to censure, owing to the fact that the hospital is undermanned and the officers are charged with more duties than they can properly perform, and also because of the fact that successful methods of controlling waste in large institutions have but recently been developed.

The Department of Bellevue has but two administrative officers. The Superintendent and the Assistant Superintendent of Bellevue are charged, not only with the supervision of Bellevue Hospital, but also that of the three allied hospitals. The supervision of the operation of Bellevue Hospital alone is a task of sufficient proportions to require the entire time of a superintendent and an assistant superintendent, and it is exceedingly difficult for two such officers to properly handle the many problems that arise in connection with the allied hospitals. It is highly probable that marked economies could be secured in the Bellevue Department if additional supervising force were provided.

Department of Public Charities

1. The gross amount of meat received by the butcher at an institution should not exceed the net amount of meat, bone, and stock delivered to the kitchens by more than 2 per cent. This 2 per cent. will account for all necessary waste in trimming and shrinkage.

2. There has been no apparent effort in the institutions of the Department of Charities to reconcile the records of the Dietitians of meat delivered to the kitchens with the records of the Storehouse of meat delivered to the institutions. The failure to reconcile such accounts has left the way clear for all sorts of waste and irregularities.

3. The large percentage of difference between the gross amount of meat received by the butcher and the amount requisitioned by the Dietitian noted in connection with Metropolitan and Kings County Hospitals indicates a lax system of accounting, and a lack of appreciation of the necessity of closely regulating the distribution of food.

4. The greater use of meat in the summer than in the winter noted in connection with some of the hospitals of the Department of Charities indicates that the Department has not maintained a definite per capita allowance, and has not taken into consideration the fact that less meat is needed in hot weather than in cold.

5. The marked difference in the supply of food per capita in the different hospitals of the Department of Charities indicates that little attempt is made to equalize the food consumption in the different institutions, and that no recognized standard of feeding is followed.

6. The administrative officials in the Department of Public Charities consist of the Commissioner of Charities; two Deputy Commissioners, connected with the central office in Manhattan; one Deputy Commissioner, in Brooklyn; a General Medical Superintendent; and a Departmental Dietitian. If the duties of these various officers were properly distributed and apportioned there would seem to be no reason why the handling of supplies in the Department should not be efficiently performed and adequately checked. The facts indicate, however, that either the duties have not been properly distributed, or there has been a neglect to perform the functions assigned.

Department of Health

1. The noteworthy difference in the supply of food per capita in Kingston Avenue Hospital and Willard Parker Hospital indicates a lack of standard for the proper feeding of patients. The fact that Riverside Hospital, which cares for tuberculous patients and some cases of mixed contagion, uses considerably more food per capita than the Otisville Sanatorium, which cares for tuberculous patients only, indicates that insufficient attention has been given to the proportions of food needed by different classes of patients.

The above conclusions are based on the food records of the Department for the year 1912. The findings of the Committee were placed in the hands of the Commissioner of Health early in the year 1913, and the irregular distribution and consumption of food noted in this report have been, in a large measure, corrected.

C. Recommendations:

Bellevue and Allied Hospitals

1. The Dietitian should be made responsible for determining the total amount of the various kinds of food needed for the Hospital.

2. The Dietitian should requisition all food on the basis of an actual count of both patients and employees, and the amount requisitioned for any particular day should be based upon the actual count on the second day preceding the day on which such requisitions are issued.

3. A per capita allowance of each kind of food should be established for patients and officers and employees. The aggregate amount of each article of food needed for the year should be based upon the daily per capita allowance. The requisitions should adhere strictly to the established allowances, and should be made to apply to the allied hospitals as well as to Bellevue Hospital.

4. A basic dietary table similar to that recommended on page 606 should be established, and, in connection therewith, a system of separating and weighing waste similar to that described on pages 603 to 605 should be installed. The basic dietary table should be corrected from time to time, according to the finding of waste of the various articles of food.

5. A business manager should be provided for the Department of Bellevue. The function of such manager should be to determine the kinds, causes, and amounts of supplies to be used, and to supervise their distribution and consumption. He should also have supervision of the care of the buildings and the employment of the help, and perform the functions of the former purchasing agent. His salary should be not less than $4,000 a year and maintenance.

6. A schedule of the yearly per capita proportions of food for use in general hospitals is set forth on page 608. It is recommended that this be adopted as a basis for estimating the amounts of the various kinds of food needed for the year.

7. A monthly statement similar to that shown opposite page 610 should be placed before the Superintendent of each institution and the General Superintendent, to inform them as to the proportions of the various kinds of food that are being used; the proportion of the budget allowance that has been consumed; and the amounts of food elements that have been supplied.

8. If the above recommendations are put into effect the saving in food cost alone in the Department of Bellevue should be not less than $30,000 a year, compared with the cost in 1912.

Department of Public Charities

1. The Dietitian should determine the average percentage of fat, bone, and trimmings that should be cut out of each carcass by the butcher in cutting up the carcass for delivery. Memoranda should be kept to see that these proportions are adhered to.

2. The distribution records for meat should be recapitulated not less than once a week, and placed in the hands of the Dietitian for comparison.

3. There should be no substitution of meats for the specific kind ordered by the kitchen, except by order of the Dietitian authorizing such substitution, which substituted order should be entered in the records.

4. The supervising Dietitian should be made responsible for determining the total amounts of the various kinds of food needed for each hospital and for each almshouse. These amounts should be based upon established schedules. It is recommended that a schedule similar to that set forth on page 608 be adopted for the general hospitals, and that the schedule set forth on page 609 be adopted for the almshouses.

5. The Dietitian should requisition all food on the basis of an actual count of both patients and employees, and the amount requisitioned for any particular day should be based upon the actual count on the second day preceding the day on which such requisitions are issued.

6. A basic dietary table similar to that recommended on page 606 should be established, and, in connection therewith, a system of separating and weighing waste similar to that described on pages 603 to 605 should be installed. The basic dietary table should be corrected from time to time, according to the finding of the amount of waste of the various articles of food.

7. A monthly statement similar to that shown opposite page 610 should be placed before the Superintendent of each institution and before the Commissioner of Charities, to inform them as to the proportions of the various kinds of food that are being used; the proportion of the budget allowance that has been consumed; and the amounts of food-elements that have been supplied.

8. If the above recommendations are put into effect the saving in meat cost alone in the hospitals of the Charities Department should be not less than $13,000 per year, compared with the cost in 1912.

Department of Health

1. It is recommended that the Department of Health use a schedule similar to that set forth on page 608 as a basis for the budgetary estimate of food needed for an ensuing year in each of the institutions caring for cases of mixed contagion, and also for institutions caring for tuberculous patients. This schedule is submitted only as tentative, and should be modified by the experience of the Department, after careful study of the needs of each class of patients.

2. A basic dietary table similar to that recommended on page 606 should be established, and, in connection therewith, a system of separating and weighing waste similar to that described on pages 603 to 605 should be installed. The basic dietary table should be corrected from time to time, according to the finding of the amount of waste of the various articles of food.

3. A monthly statement similar to that shown opposite page 610 should be placed before the Superintendent of each institution and before the Commissioner of Health, to inform them as to the proportions of the various kinds of food that are being used; the proportion of the budget allowance that has been consumed; and the amounts of food-elements that have been supplied.

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

WITH REGARD TO

CHARACTER AND COSTS OF HOSPITAL BUILDINGS

A. Summary of Findings:

1. The figures of cost of most of the newer hospital buildings were ascertained by the Committee from accounts and vouchers in the Comptroller's department. With the total cost of each known, the costs per cubic foot, per square foot, per bed, etc., were ascertained. The buildings of like character were then compared, one with another, and also with a building selected or designed as a standard. (Page 657.)

2. The cost per bed of the Nurses' Home at Kingston Avenue Hospital was $1,190, whereas the Nurses' Home at Metropolitan Hospital cost $2,157 per bed. The Nurses' Home at Kings County Hospital cost 29 cents per cubic foot, while at Sea View Hospital the cost was 44.8 cents per cubic foot. Though there was this marked difference in the cubic foot cost of these two buildings, the cost per bed was nearly the same—for Kings County Hospital Nurses' Home $1,747, and for Sea View Hospital Nurses' Home $1,820. This is due to the fact that there is an allowance of 6,000 cubic feet of space per nurse in Kings County Hospital, whereas the allowance in the Sea View Home is but 4,050. (Page 662.)

3. The amount of space provided in general rooms for the nurses ranges from 26 square feet per nurse in the Nurses' Home at Riverside Hospital to 54 square feet in the Home at Kings County Hospital. (Pages 661 to 664.)

4. The cost per bed for dormitories ranged from $633 for the Dormitory at Willard Parker Hospital to $1,202 for the Dormitory for Female Help at Metropolitan Hospital. This contrast is partly due to the difference between the costs per cubic foot, which were 27.5 cents for the Dormitory at Willard Parker Hospital and 32.6 cents for the Dormitory at Metropolitan Hospital. The chief difference, however, is in the amount of space allowed per bed, being but 2,300 cubic feet in the former and 3,680 cubic feet in the latter.

The Dormitory for Male Help at Bellevue Hospital cost 41 cents per cubic foot, while the cost per bed was but $1,186. This comparatively low cost per bed is due to the large number of beds in each room.

The Male Help Dormitory as planned for the new Greenpoint Hospital appears to provide 4,125 cubic feet per bed, which seems to be twice the number of cubic feet necessary. (Pages 667 to 670.)

5. The height of floors in all of the dormitory buildings seems to be greater than necessary. The lowest found, 11 feet, is in the Dormitory for Female Help at City Hospital. The highest is in Bellevue, where one story is 19 feet 8 inches, and the other stories are 15 feet or more. (Pages 668 and 669.)

6. The cost per bed for pavilions housing tuberculous patients of a nearly like cost per cubic foot was $657 for a pavilion at Riverside Hospital and $1,180 at Sea View Hospital. These figures are for the pavilions considered by themselves, and not the additional cost of auxiliary buildings. The cost per cubic foot of these two buildings was 34.1 cents for the Health Department pavilion and 35.5 cents for the Sea View building. The difference in the cost per bed was due to the planning of the buildings. (Pages 676 to 678.)

7. The ward buildings in connection with the general hospitals were found to vary in the matter of cost, from $855 per bed for the new wing at Kings County Hospital to $1,890 for Pavilions A and B of Bellevue Hospital. According to the plans now drawn it seems probable that the cost per bed in Greenpoint Hospital will be $2,300. These costs are only of the ward buildings, considered as units. The cost per cubic foot ranges from 28.4 cents for the new wing of Kings County Hospital to 41.6 cents for Pavilions A and B, and 36.7 cents for Pavilions L and M, of Bellevue Hospital. (Pages 670 to 675.)

8. Many of the newer buildings of the Departments of Health, Charities, and Bellevue and Allied Hospitals were examined by Edward F. Stevens, of Boston. He especially commends the buildings of the Health Department, the tuberculosis pavilions of Metropolitan Hospital, the new wing and children's pavilion of Kings County Hospital, and the new pavilions under construction at Bellevue Hospital. His criticisms in the main are as follows:

(a) Lack of utility rooms and clothes closets in connection with Riverside Hospital pavilion.

(b) Excessive height of ceilings in the scarlet fever pavilion at Willard Parker Hospital.

(c) Sea View Hospital: location of the power plant on the side whence the prevailing winds come; semicircular ground plan, not providing best exposure; insufficient bathing facilities; too many hydro-therapeutic rooms; lack of lockers for clothes; excess of sterilizers; unnecessarily expensive medicine closets; costly character of linen closets; floors with many cracks, making it difficult to keep them sanitary; surgical building unnecessarily expensive and

elaborate; and buildings so planned as to require a large number of elevators.

(d) In nearly all buildings of all hospitals: too many lights badly located; with lack of proper control, owing to regulations of the Department of Water Supply, Gas, and Electricity.

(e) In the pavilions at Bellevue: insufficient number of windows; unnecessarily heavy woodwork; excessive height of ceilings; radiators of a type not readily cleaned; insufficient elevators; plumbing fixtures too complicated. (Pages 640 to 646.)

B. Conclusions:

1. The hospital buildings have been economically built from the standpoint of cost per cubic foot, but insufficient care has been given to planning and to the handling of details.

2. Some of the nurses' homes have provided an excessive area of general rooms, and larger rooms than necessary for the nurses' bedrooms. Such planning increases the cost per bed unnecessarily.

3. It seems inadvisable to attempt to economize in building dormitories for help by providing only open dormitory rooms. Separate rooms will secure and retain a better class of help. In most cases, where such rooms have been provided, they have been made too large, thereby increasing the cost per bed unnecessarily.

4. More consideration should be given to the use to which an institution or a building is to be put before planning such institution or building. Sea View Hospital when completed will cost over $4,000 per bed, whereas, even for second stage cases, the institution, if it had been properly planned, should not have exceeded $2,000 per bed. If it was the intention to use the institution for incipient cases the cost should not have exceeded from $1,000 to $1,500 per bed. It would seem, therefore, that if the institution had been more simply planned, at least 2,000 beds could have been arranged for at Sea View instead of the 1,000 which have been provided. The cost per bed of New York State Hospital for Treatment of Incipient Pulmonary Tuberculosis, at Raybrook, was $1,500, and for the Boston Consumptives' Hospital, at Mattapan, Massachusetts, it was $1,250.

If New York City is to provide institutional care for a large proportion of the tuberculosis cases now cared for at home, the institutions for such purpose must be built upon plans much simpler than those provided for Sea View Hospital. The Department of Health is establishing standards which are very satisfactory.

5. The subordination of the interior arrangements of the Bellevue buildings to exterior architectural symmetry has resulted in excessive cost, inconvenience, and bad lighting. It seemed advisable to the original planners of the first ward buildings at Bellevue to

make the first story 18 feet 6 inches in height and all of the other stories 15 feet. Because the first building was planned and built with these dimensions it has seemed to the management advisable and necessary to continue on the original lines. If the Dormitory plans had not followed these original ideas at least two additional floors could have been incorporated in the Dormitory building without increasing its height. The excess height of the ceilings has needlessly cost Bellevue many thousands of dollars.

For the sake of economy in the construction of future buildings at Bellevue serious consideration should be given to the advisability of reducing the height of ceilings and adjusting the height of each floor to its appropriate use.

6. The buildings connected with the institutions of the Department of Health give evidence of very careful planning. Economy has been secured, both in plans and material, and at the same time the welfare of the patients has not been sacrificed.

7. It is unfortunate that the Department of Water Supply, Gas, and Electricity has power to dictate the kind and location of lights in hospital buildings. This is a matter of technical knowledge which such a department is not supposed to have and does not have. The Department's orders have resulted in very faulty and uneconomical lighting.

C. Recommendations:

1. The plans of every hospital building should be submitted to one or more hospital experts for review and suggestion.

2. Only hospital architects who have demonstrated their ability to plan economical hospitals should be employed.

3. Before any hospital building is planned buildings of a similar character in New York City and elsewhere should be studied for the best ideas as to possible economies and improvements. The tables accompanying this report should be of value in such a study. Suggestions as to plans for an out-patient department are set forth in a section of this Report dealing with the out-patient department.

4. Every building should be located and designed with a view to reducing its operating cost to as low a point as possible. The operating costs have been very little considered in planning such an institution as Sea View Hospital.

5. The demand for beds in public hospitals in New York City is so great that every reasonable effort should be put forth by the officers of each department when planning buildings to so design them as to arrangement and material that the largest number of beds possible may be provided for the least expenditure for construction and subsequent operation.

STATEMENT

WITH REGARD TO

INTERNAL CONTROL FORMS SUGGESTED FOR BELLEVUE HOSPITAL

No summary has been made of the above entitled memorandum, since forms cannot well be summarized. The memorandum presents forms suggested for purposes for which no forms are now used and also as substitutes for some of the forms in present use. The real purpose of the memorandum is to emphasize the importance of an adequate system of reports from subordinates to the superintending head of the Hospital.

STATEMENT

WITH REGARD TO

PROPOSED REORGANIZATION OF THE MEDICAL SERVICE IN BELLEVUE HOSPITAL

The memorandum bearing the above title has not been summarized, since it is both a recommendation and a plan for the reorganization of the medical and surgical service of Bellevue Hospital. Any attempt to present a summary would be wholly inadequate and of little value.

STATEMENT

WITH REGARD TO

SOME PROBLEMS COMMON TO ALL THE DEPARTMENTS

The above entitled memorandum has not been summarized since it is in itself a summary of certain conditions. To fully understand and interpret the recommendations set forth therein it will be necessary to read the entire memorandum.

Section II.—CITIZENSHIP, RESIDENCE, AND DEPENDENCE OF PUBLIC CHARGES

1. Aliens, Non-Residents, and State Poor in City Institutions
2. Admissions to City Homes (Almshouses)

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CALIFORNIA

1. ALIENS, NON-RESIDENTS, AND STATE POOR IN CITY INSTITUTIONS

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UNIV. OF CALIFORNIA

STUDY AND INVESTIGATION

BY

H. B. DINWIDDIE

FOREWORD

A. Transition in the Municipal Problem of Alien Dependence

(I) The Problem Originally a Municipal Matter

As early as 1769, before immigration began to be a matter of public record, provision was made for the maintenance of dependent immigrants in the form of a "pesthouse," established in New York City especially for them.

The tide of immigration to the United States, which arose about a century ago, found its inception in economic conditions upon the European Continent. Prior to that time immigration had not been so steady, but the famines prevailing on the Continent in 1816 and 1817 drove a large number of poverty-stricken immigrants to this country, of whom some were so destitute that they sold themselves into temporary servitude to pay their passage.

Early expression was given to the belief that aliens entailed a burden upon the community. The great mortality among the poor during the summer of 1816 was attributed by the City Inspector of the City and County of New York to the influx of immigrants of the poorer class, who had succumbed because of their physical condition and the fact that they had not become acclimated.

Much more vigorous presentation of the idea was made by interested citizens who were not public officials. The Managers of the Society for the Prevention of Pauperism, of the City of New York, in their Second Annual Report, in the year 1819, spoke of the conditions arising from the presence of immigrants "in the language of astonishment and apprehension" as follows:

> Through this inlet pauperism threatens us with the most overwhelming consequences. The present state of Europe contributes in a thousand ways to foster increasing immigration to the United States. . . .
> . . . . This country is the resort of vast numbers of these needy and wretched beings. . . . They are frequently found destitute in our streets; they seek employment at our doors; they are found in our almshouses and in our hospitals. . . .

Recognition of the heavy contribution of aliens to the almshouses was shown at an early period. In January of 1823 the Superintendent of the Almshouse of the City of New York sent the following communication to the Secretary of State:

> I send you a weekly return of our Almshouse, ending on the 5th inst., by which you will perceive we have 1,852 paupers, 1,017 of whom are natives (this last number includes all the children of foreign parents) and 835 foreigners.

Originally the supervision and care of immigrants in the United States were left entirely to the local authorities of the ports at which they were landed, the oversight of the Federal Government affecting them only in their ocean transit. Expenses of the landing and care of the immigrants

were met at first by the local authorities of New York City, from moneys levied for this purpose and collected in connection with the Poor Fund.

The pressure from those bearing, or interested in, the municipal burden of alien dependence resulted in legislative enactments. In the early history of legislation affecting immigration several important enactments were made by the Legislature of the State of New York. On February 11, 1824, the State Legislature passed an act "Concerning Passengers in Vessels Coming to the Port of New York." This act required every master and commander of every vessel arriving at the Port of New York from any country out of the United States, or from another State, to make a report in writing, on oath or affirmation, to the Mayor of the City of New York, or to the Recorder of the City, of the name, place of birth, last legal settlement, age, and occupation of every person brought as a passenger in the ship. The same act authorized the Mayor

> To require . . . every such master or commander of any ship or vessel to be bound with two sufficient sureties (to be approved of by the said Mayor or Recorder) to the Mayor, Aldermen, and Commonalty of the City of New York, in such sum as the Mayor or Recorder might think proper, not exceeding three hundred dollars for each passenger not being a citizen of the United States, to indemnify and keep harmless the said Mayor, Aldermen, and Commonalty and the Overseers of the Poor of the said City and their successors, from all and every expense or charge which shall or may be incurred by them, for the maintenance and support of every such person and for the maintenance and support of the child and children of any such person which may be born after such importation, in case such person or any such child or children shall at any time within two years from the date of such bond become chargeable to the said City.

This act was inadequate, for reasons that cannot be definitely given. Within fifteen years after its passage abnormal pressure upon the hospitals from alien patients was stated to exist, even at that very early stage, and it was also claimed that the conditions in the Almshouse had become worse. In a Memorial to the Mayor and Board of Aldermen of the City of New York by the General Committee of Native Americans, presented in June, 1837, the following statements were made:

> On the 1st of January, 1837, 982 foreigners and 227 native American citizens had been admitted to the Hospital at Bellevue (in one year). The preceding year, on the 1st of May last, there were in the Almshouse 1,437 paupers. Allowing the same proportion as in the Hospital, there will be 1,068 foreigners and 369 native American citizens in the Almshouse.
>
> It appears from the report of a Commission monthly appointed by the Board of Aldermen of this City that there are, at the date of this report, 3,070 paupers in the Almshouse, more than three-fourths of whom are foreigners. How many more of this class live upon private charities?

Prior to this time, beginning in the year 1824, when an act was passed by which it was attempted to place the burden of dependence of immigrants upon the steamship authorities, a tax, under State authority, was levied upon the passengers arriving at the Port of New York for the support of the Marine Hospital at Quarantine. This hospital provided for passengers suffering from contagious diseases only.

With the rapidly increasing immigration during the time from 1840 to 1847 the enforcement of this act was found to be very inconvenient to ship owners, and entirely inadequate for furnishing necessary aid and relief to the immigrants who became sick or destitute. The establishment of small private hospitals—from motives of economy—resulted, so that sick and infirm aliens might be cared for in them, instead of public institutions, at the expense of the shipping authorities. As the bonds required

in this act remained uncancelled for a long time, they became onerous, especially to the better class of ship owners, while sometimes, in the case of others, it was found impracticable to enforce the agreement.

(II) The Attempt to Assign the Problem to the State

The cause of dependence was long ago traced to the deficiency in the physical and financial condition of aliens at landing. In his report for 1846 the Comptroller, John Ewen, of the City of New York, called attention to "foreign paupers who, in some instances, within a day or two after landing, were taken from the wharves in large numbers in a state of destitution and sent to the Almshouse." The number of diseased immigrants increased out of proportion to the increase in immigration, and was considered a menace to public health.

The most serious objection raised to the act of 1824 had been that this effort had not resulted in sufficient provision for the care and relief of the needy immigrant. No relief had been afforded for those needing it from causes other than disease.

Consequently, in the year 1847 an act designed to meet the needs was passed by the Legislature of this State. This law provided a permanent commission for the relief and protection of alien immigrants arriving at the Port of New York. These immigrants, by this law, were entitled to aid for five years after their arrival, from a fund created by a small commutation payment for each immigrant. All the property at Quarantine Hospital, and the government thereof, were transferred to this Commission of Emigration, and other institutions for immigrants subsequently built were placed under its control.

This State Commission of Emigration erected a hospital on Ward's Island; also a nursery building for children, containing dormitories and facilities for the education and recreation of the children of the immigrants. The immigrants who had been landed in an insane condition from the ships, or had been found so afflicted in this vicinity, were accommodated in an asylum on Blackwell's Island. Cases of accident or emergent illness were cared for at the New York Hospital, by an arrangement made with that institution, such patients being transferred to the Ward's Island Hospital or the Marine Hospital, as soon as possible.

The Commissioners of Emigration, created by this act, were responsible for reimbursing the City for the expenses of the different classes of aliens described, from a fund raised by requiring a small payment for each immigrant. Within a very few years the City found considerable difficulty in securing this reimbursement. Bills were long outstanding, and the debt claimed by the board of Governors of the Almshouse for the support and maintenance of aliens in the Almshouse, Lunatic Asylum, and Hospital,[1] on behalf of the City, became the subject of bitter controversy.

Over half a century ago a complaint arose on the part of the charitable agents of the City that the State authorities whose function it was to relieve the communities of the burden of alien dependents were not fulfilling their task, and were arbitrarily deciding that the burden of many aliens should not be taken off the City by them. In the Seventh Annual

[1] The records are not clear as to the official titles of the City's early institutions, but inasmuch as the reference to Governors of the Almshouse requires the capitalization of the name of that institution, the same form has been followed in the designation of the others.—Editor.

Report of the Board of Governors of the Almshouse, for the year 1855, they registered the following complaint:

> The Board need not remind you that they refer to the unjust imposition upon the citizens of New York by the large number of vagrants, prisoners, and lunatics, as well as outdoor poor, who are thrown upon them through the inability of the Commissioners of Emigration to support those who are thrown upon public charity during the first five years of their residence here. The sum already expended has reached $60,000, without including all previous time when no account was rendered. This evil still exists, and, unless some action is had to remedy it, the burden will reach beyond the present claims made for their support.

The rejoinder of the Commissioners of Emigration was that many of the immigrants who were a burden upon the City had been committed to the institutions under the charge of the Governors of the Almshouse for vagrancy, for which reason they did not feel called upon to pay for their maintenance.

By act of the Legislature in 1855 certain classes of these immigrants who had been confined after conviction as vagrants and disorderly persons were specified as being proper charges for maintenance by the Emigration Commission. However, in the year 1856, the Board of Governors, in their Eighth Annual Report, stated, in regard to the burden upon them, that:

> During the last year nothing has been received from the Commissioners of Emigration except a trifling amount for actual services and disbursements for the burying of the dead.

And in the report of the Governors of the Almshouse in 1857 the following testimony was given:

> That out of 597 patients remaining in the Lunatic Asylum on January 18, 1857, 77 were recent immigrants entitled to support from the Commissioners of Emigration, the law requiring such shall thus be maintained until the expiration of five years after landing in New York.
>
> 111 admitted as recent immigrants by reason of the expiration of the time during which they would be chargeable to the Commissioners, remain a charge upon the City. No residence has been obtained so as legally to entitle them to support. Some who had never resided in this City were sent from other counties of the State when the five years had nearly expired.
>
> 25 had been admitted within a year after their support by the Commissioners had ceased, of whom many were inmates of Ward's Island, and a few transferred directly from that place. . . .
>
> 71 per cent. of the inmates of Blackwell's Island Hospital were foreigners; 72 per cent. of the inmates of the Penitentiary; 75 per cent. of the Workhouse; and 75 per cent. of the Almshouse were foreigners.

In spite of the deficiency, as claimed, in the relief afforded by the State Emigration Commission this relief was of a very substantial nature for those days, and large expenditures of money that would otherwise have fallen upon the community were defrayed by the "immigration fund" of the State Commissioners of Emigration. These Commissioners of Emigration reported that the aggregate sum they had expended in New York City, which represented the extent to which the City had been relieved from the burden of caring for the immigrant dependents from the year 1847, when the Commission was organized, to the year 1855, had amounted to $2,250,000.

Commissioner of Emigration Friedrich Kapp, in a paper read before the American Social Science Association at New York on October 27, 1869, stated that the cost of maintaining 11,513 inmates of the hospitals and asylums on Ward's Island was $230,000 (for the preceding year), in addition

to which a little over $100,000 was paid to the hospitals, and cities and counties of the State, for the nursing and support of immigrants.

In their argument against the question of Federal supervision of immigration, which had then arisen, the Commissioners of Emigration in 1873 submitted a review to the Senate of the United States of their work, of which the following is an extract:

1 Number of alien immigrants arrived at the Port of New York from May 5, 1847, to December 31, 1872, for whom commutation money was paid..... 5,033,392
Of which number the Commissioners of Emigration provided and cared for out of the emigrant fund for a greater or less period during the five years subsequent to arrival..... 1,465,579
as follows:

Number treated and cared for in the institutions of the Commissioners of Emigration.....	398,643
Number supplied temporarily with board, lodging, and money relief in the City of New York.....	449,275
Number provided with employment through the Labor Bureau at Castle Garden.....	349,936
Number forwarded from Castle Garden to destination in United States at their own request.....	53,083
Number relieved and provided for in various counties and institutions at the expense of Commissioners of Emigration.....	214,642

2 That the advantages of all this costly and elaborate provision, gradually perfected through many years, ought not to be lightly cast aside.

3 That without radical changes in the law of the land, it would be impossible for a Federal Bureau to extend to the arriving immigrant the same amount and kind of protection that the organization of the New York State Commission enables it to render.

The Federal law does not recognize paupers who are subjects only of local law, and the effect of abolishing the State Commission would apparently be to throw the impoverished or invalid immigrant on local charity for maintenance. This would be to inflict a heavy, unnecessary, and very unequal burden on the people, to excite local prejudice against immigration, and, by making the immigrant the recipient of alms, to hurt him fatally in all the qualities that constitute a useful citizen. The help the State Commission gives him he may take without humiliation or loss of self-respect, since it is paid for by himself, and dispensed by his own trustees. A Federal Bureau must leave him in sickness and poverty to the degrading succor of the poorhouse.

(III) Federal Action upon State Handling of the Problem

In January, 1875, the validity of the New York State law requiring a bond from the shipping authorities, and permitting commutation payments thereon to be made by the immigrant passengers, was brought before the Supreme Court of the United States. In March, 1876, the Supreme Court declared this law unconstitutional and void, and thus terminated contributions to the fund out of which the Commissioners of Emigration furnished support to the immigrants. Because State officials had issued receipts for the commutation money previously paid by immigrants with the agreement that these immigrants should receive the support that should be needed during the five years after their arrival, the Legislature of New York State, in 1876, appropriated sufficient funds to execute the pledges already made to immigrants who had arrived at the Port of New York prior to this time; but no provision was made for those who arrived subsequently. The burden of their maintenance, therefore, fell upon the municipal authorities.

Repeated efforts were made for several years following to secure legislation from Congress that should furnish adequate control over immigration and protection for both the immigrant and the communities of this and other states. These efforts having failed, the pressure upon the institutions of this locality for the support and care of insane and other alien dependents resulted in an act of the Legislature in 1880, by which the New York State Board of Charities was authorized to cause to be removed to the countries from which they came, the crippled, blind, lunatic, or other infirm alien paupers sent to this country, found in any poorhouse, almshouse, or any institution of charity in the State.

In the year 1881 the Commissioners of Emigration requested an appropriation of $200,000 from the State Legislature to carry on the work of the Commission during the fiscal year ending May 1, 1882. Only $150,000 was appropriated, however, which resulted in another appeal to the Legislature and an additional appropriation of $40,000 for this fiscal year.

To avoid a recurrence of this great burden upon the State an act of the Legislature was passed in June, 1882, granting to the Commissioners of Emigration power to exclude from the benefits of the State Emigrant institutions at Castle Garden and Ward's Island passengers of such steamship companies as refused to pay to the Commissioners a sum amounting to not less than fifty cents for each alien passenger landed by them at Castle Garden. After some demur the steamship companies paid this tax until the passage of a Federal law less than three months later.

(IV) Federal Assumption of the Alien Problem

On August 3, 1882, the President approved an act of Congress for a Federal tax on ship owners of fifty cents for each alien passenger landed in ports of the United States. This act provided that:

> The Secretary of the Treasury is hereby charged with the duty of executing the provisions of this act, and with supervision over the business of immigration to the United States, and, for that purpose, he shall have power to enter into contracts with such state commission, board or officers as may be designated for that purpose by the governor of the state, to take charge of the local affairs of immigration in the ports within said state, and to provide for the support and relief of such immigrants therein landing as may fall into distress or need public aid, under the rules and regulations to be prescribed by said Secretary.

This act also prescribed that:

> It shall be the duty of such state commission, board or officers so designated, to examine into the condition of passengers arriving at the ports within such state in any ship or vessel, and, for that purpose, all or any of such commissioners or officers, or such other person or persons as they shall appoint, shall be authorized to go on board of and through any such ship or vessel; and if, on such examination, there shall be found among such passengers any convict, lunatic, idiot, or any person unable to take care of himself or herself, without becoming a public charge, they shall report the same in writing to the collector of such port, and such persons shall not be permitted to land.

The function of the State Commission, heretofore fulfilled merely as one of local interest, was hereby temporarily recognized by Federal legislation.

This act of Congress provided for relieving New York City, as well as other communities, from the burden of all aliens who became public charges within one year after arrival from causes existing prior to landing, by deportation and by reimbursement to the City at the expense of the steamship

companies. Also, the immigrants lawfully landed who became public charges within one year after date of landing and seemed likely to become chronic dependents could be removed at the expense of the "immigration fund," and the expense of their maintenance, up to the expiration of the year subsequent to their landing, could be paid out of that fund, to be collected by the United States Government by a head tax on immigrants.

(V) Inferiority of Federal Relief to that of the State

The provision previously afforded for the maintenance of all immigrants, except criminals, out of the fund of the State Commissioners of Emigration was taken away from the City when Federal authorities replaced those of the State, and the only payment offered by the Federal Government for the maintenance of aliens in an institution of this City terminated at the expiration of one year after the time of landing. Furthermore, there had been no limit placed upon the power of the State authorities as to the duration of the time after landing within which they might deport immigrants, but by the act of 1882 this was limited to one year for the Federal authorities, and although by the act of 1891 this time was extended, it was, and still is, limited to three years. Also, the time after landing within which the Federal Government could reimburse the City was reduced to three years from the five-year period for which the State had borne the maintenance. Furthermore the State law provided for the maintenance of all aliens that became dependent in the five years, but the Federal provision was only for very limited classes.

(VI) The Lapsing of the Federal Contract to Relieve the State

The contract into which the Secretary of the Treasury and the Commissioners of Emigration of the State of New York entered under the act of 1882 was discontinued March 3, 1891, when, by an act of Congress, the office of Superintendent of Immigration was created and established, although a similar contract continued for twenty years longer between the immigration authorities and the State authorities in Massachusetts. A United States Commissioner of Immigration was placed in charge of the Port of New York, and supplanted the State Commissioners of Emigration in their function by taking control of the landing, supervision, and care of immigrants at this port. At this time, when this entire control passed into the hands of Federal officials, the offices were removed from Castle Garden to the new buildings on Ellis Island.

(VII) Increasing Severity in Federal Provision for Exclusion

Although the sense of responsibility of the Federal authorities for the relief of the local authorities from the burden of dependent aliens seemed to become less definite, Federal legislation, as it progressed, exhibited increasing appreciation of the need of exclusion. The act of 1882 specified that, if there should be found among the alien passengers on ships "any convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge . . . such persons shall not be permitted to land," but by the act of 1891 (and preceding legislation) the list of excluded persons was enlarged to cover the following:

> . . . Idiots, insane persons, paupers, or persons likely to become a public charge, persons suffering from loathsome or dangerous contagious diseases, persons who might have been convicted of a felony or other infamous crime, or mis-

demeanor involving moral turpitude, polygamists and also any person whose ticket or passage had been paid for with money of another or who was assisted by others to come, unless satisfactorily shown, on special inquiry, that such person did not belong to any of the excluded classes, or to the class of contract laborers excluded by the act of 1885.

By the time the act of 1907 was passed there had been added to this list of excluded persons:

imbeciles, feeble-minded persons, epileptics, . . . persons who have been insane within five years previous; persons who have had two or more attacks of insanity at any time previously; paupers; . . . professional beggars; persons afflicted with tuberculosis; . . . persons not comprehended within any of the foregoing excluded classes who are found to be and are certified by the examining surgeon as being mentally or physically defective, such mental or physical defect being of a nature which may affect the ability of such alien to earn a living.

The list also included classes more directly affecting social problems other than those of dependence.

In a bill introduced in the 63d Congress, in 1913, as Senate Bill 50 and House of Representatives Bill 1,958, a further attempt to protect the country from the burden of dependent aliens seems evidenced by the addition to the excludable classes of the following:

male persons over sixteen years of age who do not possess in their own right $50 in lawful money of the United States or other money of equivalent value; . . . vagrants; male persons between the ages of sixteen and fifty coming to perform skilled or unskilled manual labor who are found to be and are certified by an examining surgeon, who shall call in two other examining surgeons to concur in such certification, as below the physical standard now observed for recruits for the United States naval service.

By this bill it was proposed to extend the period of time for deportation of aliens and for reimbursement of their expenses to five years after landing.

(VIII) Small Amount of Federal Relief Afforded to the City at Present

Substantial numbers of alien dependents were transferred from New York City by the Department of Public Charities to the Commissioners of Immigration twenty years ago, and the removal of aliens by the State Board of Charities was then of insignificant proportions. This transference from the Department of Public Charities to the Commissioners of Immigration ceased with the year 1905. By the order of the Commissioner of Charities who came into office in January, 1906, all aliens found in the institutions of the Department were required to be referred to the Department of State and Alien Poor of the State Board of Charities. From that time to the present the relief afforded New York City institutions by the removal of aliens has been through State rather than through Federal agents.

According to the monthly reports of the Department of State and Alien Poor of the State Board of Charities for the fiscal year ended September 30, 1912, the United States Immigration Service removed only 7 aliens from the Department of Bellevue and Allied Hospitals (and the State Board of Charities only 103). According to the examination made by this Committee in 1913 there would be admitted to Bellevue Hospital alone in a year 5,600 alien patients deportable under the existing Federal and State laws.

As early as 1869 the State Commission of Emigration saved the City $230,000 in a year by maintaining immigrants (and the sum of $100,000

was paid to institutions throughout the State not under their control). The annual expense of maintaining aliens in the hospitals and almshouses of the Departments of Bellevue and Allied Hospitals and of Public Charities, on the basis of the examination made in 1912 and 1913, is estimated to be over $900,000. The average payments to the City from the State Board of Charities (as agents of the Federal Government) in 1911 was less than $10,000, and in 1910 less than $6,000. Prior to that time no payments appear to have been made.

The fund formerly collected by the State from immigrants is now collected by the Federal Government. This fund, raised by head tax, is now turned into the United States Treasury, and the expenses of the immigration service are defrayed by appropriations from the Government's general funds, and not, as heretofore, by direct expenditure of the head tax. There is a surplus of over $1,000,000 annually being turned into the United States Treasury over and above the amount drawn from that source to defray the expenses of the immigration service. Thus, a large portion of the head tax fund, originally started by the State, has been diverted from its original purpose and become a source of revenue. Meanwhile, this municipality, which bears most heavily the burden of dependence of aliens, has to supply the deficiency in the Federal relief out of its own treasury.

The Government for some years has not spent an average of $150,000 annually for its entire medical service for immigrants, inclusive of hospital facilities. Were the $1,000,000 surplus of this head tax fund devoted to the exclusion of those likely to become, and the removal of those who have become, dependents, great relief would be afforded to the City of New York.

The following is a copy of a letter recently sent to an official in New York City (a similar letter was sent to other public officials connected with the oversight of public charges):

UNITED STATES DEPARTMENT OF LABOR.

December 24, 1913.

SIR: I have to inform you that the Secretary of Labor has suspended that portion of subdivision 7, Rule 22, of the Immigration Regulations which relates to the maintenance of aliens who become public charges from causes existing prior to landing, such suspension to become effective December 31, 1913, after which date maintenance bills for the care of alien public charges will not be paid by the Government.

The necessity for this suspension lies in the fact that Congress has not sufficiently provided for the maintenance and upkeep of the Immigration Service during the current fiscal year and vigorous retrenchment is necessary. There is no requirement of law which obligates the Government to pay these bills, and the only remedy for the situation lies in an increased appropriation by Congress.

Respectfully

BYRON W. UHL

Acting Commissioner

This recent order carries still further the tendency of the Federal Government to throw upon the locality the burden of caring for aliens, whether or not such aliens have been improperly admitted by Federal officers.

B. Some Points of Contrast between the Handling of Alien, Non-Resident, and State Poor Dependents in the State of Massachusetts and in the State of New York

(I) Aliens

(a) *Agreement between the State and United States Authorities*

For a period of many years prior to June 30, 1911, there was in existence an annually renewed contract between the State Board of Charity of the State of Massachusetts and the Commissioner of Immigration at the Port of Boston, by which the Immigration Service agreed to reimburse, at a stipulated rate, the State Board of Charity for aliens maintained in the hospitals or elsewhere within the State who had become public charges by reason of accident, bodily ailment, disease, or physical or mental inability to earn a living.

This agreement bound the Immigration Service to reimburse the State Board of Charity for (1) the aliens who had become public charges from causes arising subsequent to landing until deportation or until the expiration of one year after the alien's entry into the United States, and (2) for the aliens who had become public charges from causes existing prior to arrival in this country, and whose deportation was ordered by the Department of Commerce and Labor for this reason, from the date that the Secretary of Commerce and Labor issued a warrant for the arrest of the particular alien up to the time of the deportation. Under the contracts prior to that existing for the year 1910-1911 the United States Government was liable for maintenance charges of aliens who were public charges from prior causes from the date of notification by the State authorities that the particular alien was a public charge, and not from the date that the warrant for this alien's arrest for deportation was issued.

The State Board of Charity agreed to transport to and receive into the hospitals and institutions under its control the above classes of aliens, and to furnish them all necessary treatment and care, or to supply this at their residences in case life or public health would be jeopardized by removal.

In the City of New York aliens are maintained at a heavy expense without any agreement between the United States officials and the municipal or State authorities, and the City is reimbursed only for a negligible proportion of its expenditure in maintaining these aliens. In the years from 1902 to 1905 the Department of Public Charities referred considerable numbers of aliens directly to the Commissioner of Immigration. These aliens were maintained, it is understood, in the institutions at Ellis Island at the expense of the Federal Government and the City was thereby relieved. After the year 1905 this practice was discontinued, and, although there are large numbers of aliens being supported in the municipal institutions, no such relief is afforded the City at the present time.

(b) *Removal Agencies*

Under the law of the State of Massachusetts the overseers of the poor in their respective places are required to report immediately to the State Board of Charity every recipient of public relief not having a legal settlement within the State, and the State Board of Charity is authorized to remove such persons to the State Hospital or to any place to which they may belong. Also, a justice of the superior court, or of a police, district, or municipal court, or a trial justice may, upon an application by the overseers

of the poor of any place, or by the State Board of Charity, by a warrant directed to a constable or other person therein designated, cause any alien or non-resident pauper who is not a proper public charge within the State to be conveyed to the country where he belongs.

In the City of New York relief is afforded to the City poor authorities from the burden of alien dependents through application to either the State Board of Charities or the United States Immigration Service. There is no specific power for enforced removal conferred upon any local authority.

(II) Non-Residents

(a) Non-Residents of the State

In the State of Massachusetts only those non-residents of the State seem to be permissible as charges upon the local authorities whose maintenance is considered to be for the public interest. Poor persons without a settlement in the State are designated as State Paupers and may be sent by the overseers of the poor to the State hospital, to be maintained at the public charge. Their removal from the State may be effected by the State Board of Charity.

The State Board of Charities of the State of New York is authorized to remove non-residents of the State therefrom, but no provision is made for their maintenance at the expense of the State, except in the case of such as have lived less than sixty days in any county of the State within one year preceding the date of their application for relief. This limited class is referred to under the title of State Poor.

All non-residents of the State maintained in the New York municipal institutions that have been in the City more than sixty days are maintained entirely at the municipal expense.

(b) Non-Residents of Towns and Cities

Dependents who have a lawful settlement at other places within the State of Massachusetts must be afforded immediate relief by the overseers of the poor in any place in which these dependents shall fall into distress and stand in need of relief, until their removal to the place of their settlement. The expense, however, of their maintenance, of their removal, or of their burial in case of their decease, may be recovered by an action against the place where the dependent belongs.

Provision is made in the law of the State of New York for the recovery of the expense of the support of a poor person who shall come into a county or town not legally chargeable with his support. This recovery may be made by the overseers of the poor furnishing this support from the poor authorities of the place where the poor person has his legal settlement. Under the interpretation of the Supreme Court, however, this provision of the law has been held not to authorize such recovery when a person has become a poor person *after* he has left the town or county in which he had gained a settlement.

Therefore, there falls upon the overseers of the poor of the City of New York the burden of maintaining as public charges those poor persons without lawful settlement in the City who were not public charges as poor persons in the place of their legal settlement, although this settlement may have been of lifelong duration.

(III) State Poor

In the State of Massachusetts all poor persons who have no legal settlement within the State are State Paupers, for whose expense the State is liable, either by maintenance in State institutions or by reimbursement to local authorities. A settlement of five years in a city or town is the general requirement to entitle a poor person to maintenance by the city or town.

A State Poor person in the State of New York is a dependent who has not resided in any county within the State for sixty days within one year preceding the time of application by him to any overseer of the poor for aid. Under the law these persons must be maintained in the State Almshouses only. The burden of the maintenance of all non-residents of the State as poor persons who have resided in this City for sixty days and over within the year preceding the time of application for relief falls upon the community, although these poor persons may have their legal settlement elsewhere.

(IV) Reimbursement

The Boston City Hospital sends bills for patients it treats to the cities or towns in which they are supposed to have a settlement. The Hospital also receives from the State of Massachusetts reimbursement for the board of patients. In the year ended January 31, 1913, this Hospital received $29,596 from the State for the board of patients, and $24,512 from the cities and towns for the board of patients, or a total of $54,108.

Bellevue Hospital, in the City of New York, which had approximately four times as many admissions as the Boston City Hospital, received in the year 1912 no payments whatever from State funds for persons with less than sixty days residence in the State, and received no reimbursement from the other cities and towns for persons having legal settlements in them. A small amount of money was transmitted to Bellevue Hospital by checks of the State Board of Charities for alien patients in this Hospital, but this money had been forwarded to the State Board of Charities by the United States Government, and was not a State expenditure.

If the law provided for payments to Bellevue Hospital from the State, and from the county overseers of the poor, as provided in Massachusetts, and if the payments for such patients bore the same proportion to the admissions as in the Boston City Hospital, Bellevue would receive approximately $200,000 a year from the State and localities within it.

SOME PREVIOUS PRESENTATIONS AND LEGISLATIVE PROVISIONS

Aliens

For the last 100 years there has been more or less agitation regarding the presence of aliens in the State and City of New York whose maintenance has been provided for out of the City's treasury.

As early as the year 1769 a "pesthouse" was established in New York City, "especially for the reception of diseased immigrants." Because a very large proportion of immigrants to this country have entered through the Port of New York, the pressure upon this City has naturally been pronounced. Not only have the diseased immigrants been a burden upon our municipality, but the destitute and unemployed have entered our municipal institutions in large numbers. At various times the proportion of aliens in our charitable institutions has been reported by public officials. Frequently, however, it has appeared that the institutions have not distinguished between foreign born dependents who had become naturalized citizens and those who were still citizens of other countries.

Foreign Born in Municipal Institutions

The Annual Report of the Commissioner-General of Immigration for the year ended June 30, 1912, shows that, of a total immigration of 838,172 persons, 239,275, or 28.5 per cent. of the total, were aliens who had declared their intention of establishing their permanent residence within the State of New York. The average proportion of this class for the 8 years ended at the same date is over 30 per cent. The mental and physical ability of these intended residents is a matter of fundamental concern to the City.

Many thousands of the immigrants to this country have found their way into the charitable institutions of this community and have been maintained at public expense. According to the Forty-fifth Annual Report of the State Board of Charities, for the year ending September 30, 1911, there were supported in the institutions of the Department of Public Charities, exclusive of the Municipal Lodging House, a total of 28,585 foreign-born dependents, or 52 per cent. of the entire number supported during the year. In the same year there were 25,835 foreign born patients in the hospitals of the Department of Bellevue and Allied Hospitals, who formed 49 per cent. of the total patients maintained in these institutions in this year. In other words, in the institutions within these two Departments there was a total of 54,420 foreign born dependents, who were 50 per cent. of the entire number maintained in these institutions during this year. (Pages 108 and 110 of Appendix to Volume I, State Board of Charities Annual Report for 1911.)

The Report of the Commission of Immigration of the State of New York, appointed by Governor Hughes, transmitted to the Legislature April 5, 1909, stated that 90,776 foreign born poor persons were relieved in the several counties of this State during the year ended September 30, 1907, who constituted 44.2 per cent. of the entire number of public beneficiaries so relieved whose nativity could be determined. (See page 186 of that Report.) Were the proportion of foreign born among those whose nativity

could not be determined the same as among those that could be classified according to nativity, the number of foreign born poor persons relieved in the counties of New York State during that year would have been 104,448.

According to the Appendix (page 201) of the Report just referred to, 8,215 foreign born lodgers were admitted during the first quarter of 1908 to the Municipal Lodging House, New York City, who constituted 53.8 per cent. of the total admissions in that period. Including the native born, 23.5 per cent. of the total admissions in this period had been in the City 60 days and less. It is not stated how many of the foreign born dependents had become naturalized.

Table I, on page 74, shows the foreign born admissions to the institutions in the Departments of Charities and Bellevue and Allied Hospitals in the year 1911 to have been 120,152. The admissions to the New York Children's Hospitals and Schools are not entered in this table, as the nativity of its inmates does not appear in connection with its section in the Annual Report of the Department of Public Charities. A study of this table shows that the admissions of foreign born to the almshouses were 70 per cent., 65 per cent., and 63 per cent. of the total number of admissions in the Manhattan, Brooklyn, and Richmond almshouses, respectively. The Manhattan hospitals of this Department come next in proportion of foreign born, the proportion in City Hospital having been 59 per cent. of the total admissions, while Metropolitan Hospital had 55 per cent. of foreign born. The percentage in the Brooklyn hospitals was much lower, having been 40 per cent. in Kings County Hospital; 34 per cent. in Coney Island Hospital; 32 per cent. in Bradford Street Hospital; and 25 per cent. in Cumberland Street Hospital. The general average of foreign born in almshouses in this Department was 67 per cent., and in the hospitals 47 per cent. The Municipal Lodging House showed a proportion of 43 per cent. foreign born.

Similarly, Bellevue and Allied Hospitals were found to have had 50 per cent. of their total admissions composed of foreign born patients. The total number of admissions of foreign born involved was 25,737. The proportion of foreign born varied between 40 per cent. of the total admissions to Harlem Hospital, and 62 per cent. of the total admissions to Gouverneur Hospital; Fordham Hospital, with 42 per cent., and Bellevue Hospital, with 52 per cent., coming within those percentages.

There were 42,038 admissions of foreign born patients to the hospitals in these two Departments during this year, which number formed 49 per cent. of the total admissions to these institutions. These figures are taken from the Annual Reports of these institutions, but, unfortunately, it is not known what proportion of these foreign born had been naturalized.

The Federal Immigration Commission made an examination of the patients admitted to Bellevue and Allied Hospitals during the 7 months period from August 1, 1908, to February 28, 1909. Of the total of 23,758 charity cases covered by the investigation, 12,426, or 51.5 per cent., were of foreign birth, and were maintained by the City, as was estimated, at an expense of $257,761. Under this same investigation it was found that 28 per cent. of these foreign born patients had been in the United States less than 5 years, and 17.9 per cent. were admissions of foreign born who had been in the United States less than 3 years.

The proportion of foreign born patients within this Department has not varied greatly for some years, according to the Annual Reports of the Department, there having been 53 per cent. in 1908; 52 per cent. in 1909; the

same proportion in 1910; 50 per cent. in 1911; and 49 per cent. in 1912. Neither the tables of the Immigration Commission nor the records of the Hospital give an indication as to what proportion of these foreign-born patients were citizens of the United States.

Exclusion of Aliens

By the United States Immigration Law, Act of February 20, 1907, it was enacted that certain classes of aliens should be excluded from admission into the United States.

That some protection is afforded to this community by the United States Government may be inferred from the report of the Commissioner-General of Immigration regarding the number of aliens debarred from entering the country. These amounted to 16,057 individuals in the year 1912, a smaller number than was excluded in either of the 2 preceding years. This report does not state how many of these debarred aliens had selected New York as a future residence.

Removal of Aliens

That many aliens have become a burden upon this State and community is evident from the reports of the agencies empowered to bring about their removal. The agencies having this power are the United States Immigration Service, the New York State Board of Charities, the New York State Hospital Commission, and the New York State Department of Labor. These agencies remove both those alien dependents who are found to have been illegally admitted to the United States, or to be illegally within the country, and also those who prefer to be repatriated rather than to live in an institution among a strange people. Removal is not merely a relief to public expenditure, but may be a genuine charity to the dependent and the dependent's friends.

(a) The United States Immigration Service

As a provision for the relief of the different communities of this country from what was considered an unwarranted burden upon their charity the Federal law authorized the return of certain classes of aliens from the United States. In the United States Immigration Law, Act of February 20, 1907, as amended, it was enacted:

> § 2. That the following classes of aliens shall be excluded from admission into the United States: All idiots, imbeciles, feeble-minded persons, epileptics, insane persons, and persons who have been insane within five years previous; persons who have had two or more attacks of insanity at any time previously; paupers; persons likely to become a public charge; professional beggars; persons afflicted with tuberculosis or with a loathsome or dangerous contagious disease; persons not comprehended within any of the foregoing excluded classes who are found to be and are certified by the examining surgeon as being mentally or physically defective, such mental or physical defect being of a nature which may affect the ability of such alien to earn a living; . . .
>
> § 3. That . . . any alien who shall be found an inmate of . . . a house of prostitution or practicing prostitution after such alien shall have entered the United States, . . . or who is employed by, in, or in connection with any house of prostitution or music or dance hall or other place of amusement or resort habitually frequented by prostitutes, or where prostitutes gather, . . . shall be deemed to be unlawfully within the United States and shall be deported in the manner provided by sections twenty and twenty-one of this Act . . .

§ 19. That all aliens brought to this country in violation of law shall, if practicable, be immediately sent back to the country whence they respectively came on the vessels bringing them. The cost of their maintenance while on land, as well as the expense of the return of such aliens, shall be borne by the owner or owners of the vessels on which they respectively came; . . .

§ 20. That any alien who shall enter the United States in violation of the law, and such as become public charges from causes existing prior to landing, shall, upon the warrant of the Secretary of Commerce and Labor, be taken into custody and deported to the country whence he came at any time within three years after the date of his entry into the United States. Such deportation, including one-half of the entire cost of removal to the port of deportation, shall be at the expense of the contractor, procurer, or other person by whom the alien was unlawfully induced to enter the United States, or, if that cannot be done, then the cost of removal to the port of deportation shall be at the expense of the "immigrant fund" provided for in section one of this Act, and the deportation from such port shall be at the expense of the owner or owners of such vessel or transportation line by which such aliens respectively came: . . .

§ 21. That in case the Secretary of Commerce and Labor shall be satisfied that an alien has been found in the United States in violation of this Act, or that an alien is subject to deportation under the provisions of this Act or of any law of the United States, he shall cause such alien within the period of three years after landing or entry therein to be taken into custody and returned to the country whence he came, as provided by section twenty of this Act, . . .

By a regulation of the Bureau of Immigration and Naturalization of the Department of Commerce and Labor, in force in 1907, the following provision was made for the deportation of aliens who had become public charges from causes arising subsequent to landing:

Rule 39. Deportation by consent.—Any alien who has been lawfully landed, but who has become a public charge from subsequently arising physical inability to earn a living, may, by consent of the alien and with the approval of the Bureau of Immigration and Naturalization, be deported within one year from date of landing at the expense of the immigration fund: Provided, that such alien is delivered to the immigration officers at a designated port free of charge; and the charges incurred for the care and treatment of any such alien in any public or charitable institution from the date of notification to an officer of the Bureau until the expiration of one year after landing may be paid from the immigration fund at fixed rates agreed upon.

(*b*) *The State Board of Charities*

Although the Federal Government's power of removal of an alien improperly admitted to the United States ceases after he has been in the country for 3 years, we find no such limitation in the following provision of the State law that confers upon the State Board of Charities authority for removals:

State Charities Law, constituting chapter 55 of the Consolidated Laws.

§ 17. State, non-resident, and alien poor. . . . The State Board of Charities, and any of its members or officers, may, at any time, visit and inspect any institution subject to its supervision to ascertain if any inmates supported therein at a state, county or municipal expense are State charges, non-residents or alien poor; and it may cause to be removed to the state or country from which he came any such non-resident or alien poor found in any such institution.

(*c*) *The State Hospital Commission*

The Insanity Law, as amended in January, 1912, Chapter 27 of the Consolidated Laws, provides:

First: That such Bureau[1] shall examine and inspect alien and non-resident insane persons, and alleged insane persons in the State hospitals, other public insti-

[1] Otherwise known as the State Board of Alienists.

tutions and elsewhere where such insane persons and alleged insane persons may be for the purpose of determining whether they are suitable cases for deportation under the immigration law, or removal under the provisions of this section to other countries or states, and shall notify the proper authorities having control of the enforcement of the immigration laws at the ports of entry of such immigrants as are found to be insane, idiotic, imbecile or epileptic, and such insane aliens as are or become public charges, or who are in the country in violation of law, and shall arrange for their deportation in accordance with the provisions of such laws.

Second: The bureau may, upon the request of any indigent insane person, or the written consent of their relatives, legal representatives, or qualified friends, subject to the approval of the Commission, remove such patients to any country, state or place to which they may properly belong.

—Report of Bureau of Deportation to the State Hospital Commission for year ending September 30, 1912.

(d) *Bureau of Industries and Immigration, New York State Department of Labor*

The power for the other agency of removal was given as follows:

New York State Laws of 1910, Chapter 514,
Article 10A.

Section 153, Subd. 4. The commissioner of labor may . . . secure information with respect to such aliens who shall be in prisons, almshouses and insane asylums of the State, and who shall be deportable under the laws of the United States, and co-operate with the Federal authorities and with such officials of the State having jurisdiction over such criminals, paupers and insane aliens who shall be confined as aforesaid, so as to facilitate the deportation of such persons as shall come within the provisions of the aforesaid laws of the United States, relating to deportation. . . .

The New York State Bureau of Industries and Immigration of the State Department of Labor did little toward relieving the community and State of their burdens, judging from the following quotation from its First Annual Report, for the year ending September 30, 1911:

(The Bureau) . . . has, therefore, in co-operation with the State authorities charged with these matters, dealt only with a few cases of deportation brought to its attention, and has gathered no statistics.

The other two State bodies coöperate with the United States Immigration Service, making the preliminary investigations and referring the cases to the Government for action. Many of the deportations reported by the State bodies are duplicated in the number reported by the United States authorities. The coöperation between the State and Government authorities is very important in making the work of the State bodies effective. Though empowered by State laws to take steps toward removal, the power of the State Boards stops at the boundary line of the State. The control over the steamship companies pertains to the Federal Government, and it is under its compulsion that unwilling transportation companies carry aliens, illegally in this country, to their native lands.

The relief afforded the City by the marked activity of the State Board of Alienists in recent years has been indirect, rather than direct, as a large majority of the removals effected through this Board occur after the aliens have been committed to State institutions. The State Board of Alienists, however, according to its annual reports, has been effective in returning a

higher yearly average of aliens during the period of its existence than the State Board of Charities, the average number of alien removals on the part of the State Board of Alienists having been about 500 cases annually, while for the 33 years from 1880 to 1912 the State Board of Charities has averaged only 266 removals a year. It is not known what proportion of the removals by the State Boards have been from the City of New York.

As will be seen by reference to Table II, according to the Annual Reports of the Department of Public Charities for the years from 1902 to 1905, inclusive, 2,369 aliens were transferred in these 4 years by the Department of Public Charities to the Commissioners of Immigration from New York City alone. This number was over 2,000 in excess of the total number of removals from the entire State of New York, including New York City, by the Department of State and Alien Poor of the State Board of Charities in the same years. Although the number of these removals by the Department of Charities diminished yearly, from 1,137 in 1902 to 861 in 1903, 328 in 1904, and to only 43 in 1905, the average yearly number of removals by this Department exclusively from this City for these 4 years was 592, as compared with the yearly average of 91 for the same years, and of 420 for the 10 years from 1902 to 1911, inclusive, by the State Board of Charities from the entire State, including the City of New York. The direct removal of aliens by the Department of Public Charities to the Commissioners of Immigration appears to have ceased with the year 1905, as no entries of such removals are found in its Annual Reports after that year.

Non-Residents

(a) Non-Residents of New York State

As a matter of general practice the State makes no provision for the exclusion of residents of other states from its confines, although its laws make it a misdemeanor to bring any poor person from without the State to make him wrongfully chargeable upon any county or town in the State, or upon the State itself.

There are, however, powers, additional to those for the removal of aliens, conferred upon two of the State bodies; namely, the State Board of Charities, and the State Board of Alienists. These powers provide for the removal of dependents who have not established a legal settlement in New York State to the other states from which they have come. The easy accessibility of this State, especially this City, from the neighboring states has made it possible for many who should not properly be dependents within the State to come, or be sent, here and to become public charges upon the municipality. As these adjoining states do not have boards of central control authorized to receive non-residents of other states for return to the places of their legal settlement, our authorities whose business it is to remove improper residents of charitable institutions have not always found a ready acceptance of the non-residents of New York State that they desire to return to adjoining states. Again, the laws of the adjoining states defining the settlement which a poor, sick, or insane person must have to be eligible for maintenance in a state, county, or town institution vary from those of New York State. On account of this lack of uniformity, the authorities within this State are not infrequently unable to find support for their requests for the acceptance of non-residents of New York State in the law of other states.

(b) Non-Residents of New York City

The basis of deciding upon what officials falls the responsibility for the maintenance of a poor person is the settlement of the applicant for relief. The general statement regarding this settlement is found in the following section of the Poor Law:

ARTICLE 4.

§ 40. *Settlements, how gained.* Every person of full age, who shall be a resident and inhabitant of any town or city for one year, and the members of his family who shall not have gained a separate settlement, shall be deemed settled in such town or city, and shall so remain until he shall have gained a like settlement in some other town or city in this State, or shall remove from this State and remain therefrom one year. . . .

Such a poor person may not be removed from one locality to another within the State by the authorities of the locality in which he is supported as a poor person:

§ 42. *Poor persons not to be removed, and how supported.* No person shall be removed as a poor person from any city or town to any other city or town of the same or any other county, nor from any county to any other county except as hereinafter provided; but every poor person, except the state poor, shall be supported in the town or county where he may be, as follows:

1. If he has gained a settlement in any town or city in such county, he shall be maintained by such town or city.

2. If he has not gained a settlement in any town or city in the county in which he shall become poor, sick or infirm, he shall be supported and relieved by the superintendents of the poor at the expense of the county . . .

The communities, however, into which an indigent person may enter in search of relief are not without redress from the burden upon them of the maintenance of such an individual, as the following means of relief is afforded them:

§ 51. *Proceedings to compel support.* A poor person so removed, brought or enticed, or who shall of his own accord come or stray from one city, town or county into any other city, town or county not legally chargeable with his support, shall be maintained by the county superintendents of the county where he may be. They may give notice to either of the overseers of the poor of the town or city from which he was brought or enticed, or came as aforesaid, if such town or city be liable for his support, and if there be no town or city in the county from which he was brought or enticed or came, liable for his support, then to either of the county superintendents of the poor of such county, within ten days after acquiring knowledge of such improper removal, informing them of such improper removal, and requiring them forthwith to take charge of such poor person. . . .

This section of the Poor Law has been interpreted to apply only to persons whose dependence begins *after* leaving the places of their settlement, according to the following extract from the State Board of Charities Report for 1911, Vol. III, page 351:

Held that, when a person becomes a "poor person" after he has left the town or county in which he has gained a settlement, he must be supported by the county in which he becomes a poor person, without right on the part of such county to reimbursement from the town or county from which he came, even though his settlement still remains there. *Supreme Court, App. Div.*, May 3, 1905, *Delaware County v. Town of Delaware, Sullivan County*, 93 N. Y. Supp. 954.

By the above interpretation it will be seen that the town or county poor authorities have not equal opportunity of relieving their communities of the maintenance of a dependent whose settlement is in another county or town

in this State, with that which they have of relieving them in the case of a dependent with settlement outside of the State. According to this rendering of the law the burden can be put upon the place of his settlement only in the case of a dependent who was a "poor person" in the locality of his settlement prior to his coming to the community which desires relief, whereas, all dependents who have not established a settlement within this State may, within the discretion of the State Board of Charities, be removed to the states from which they came.

State Poor

The recognition of the duty of the State to relieve communities of the expense of maintaining dependent poor who have not established a legal settlement in these communities is expressed in the following extract from the report of the Committee on State and Alien Poor, of the State Board of Charities, in Vol. I of the Annual Report of the Board for 1902, page 351:

> To prevent imposition as far as possible and to relieve the several communities of the State of the care of such destitute non-residents is the special function of the Department of State and Alien Poor. It is not to be expected that all persons who come to this State will prove thrifty and successful. Accidents happen and misfortune is common. Too many people come with barely sufficient means to pay their transportation to the State; others, with more means, meet with disappointment, misfortune or disaster. In all cases, as they are non-residents without a legal claim upon a county, they must be removed at the expense of the State. It is just that the State should itself assume the care and removal of persons of this character, and in the end the expenses incurred under the law prove economical.

The definition of the class of dependents for whom the State is responsible will be found in the following section of the Poor Law, Article 7:

> § 90. *Who are state poor, and how relieved.* Any poor person who shall not have resided sixty days in any county in this State within one year preceding the time of an application by him for aid to any superintendent or overseer of the poor, or other officer charged with the support and relief of poor persons, shall be deemed to be a state poor person, and shall be maintained as in this article provided. The state board of charities shall, from time to time, on behalf of the state, contract for such time, and on such terms as it may deem proper, with the authorities of not more than fifteen counties or cities of this State, for the reception and support, in the almshouses of such counties or cities respectively, of such poor persons as may be committed thereto.

The following quotation from the law prescribes the method of maintenance of such persons:

> § 92. *State poor to be conveyed to state almshouse.* County superintendents of the poor, or officers exercising like powers, on satisfactory proof being made that the person so applying for relief as a State poor person, as defined by this chapter, is such poor person, shall, by a warrant issued to any proper person or officer, cause such person, if not a child under sixteen years of age, to be conveyed to the nearest state almshouse, where he shall be maintained until duly discharged, . . .

Though the law gives a specific definition of State poor persons, the impracticability in New York City of its requirement that these shall be maintained in the State Almshouses is evident.

The number of State Poor committed to all the almshouses of the State will be found in Table III. From this table it will be learned that from the year in which the State Poor Law of 1873 went into operation

up to the year 1899 there was a general increase in the number of State Poor committed annually to the county or town almshouses that had been designated in accordance with the law as State Almshouses, after contract with the county and town authorities. The total number of State Poor committed in 1874 was 563, and in 1899 it was 2,049. The average number of commitments for the first 4 years of this period in the entire State, including New York City, was 680. The average number in the next 8 years was 1,498, which was 818 more than in the first 4 years. The average number for the next 8 years, from 1886 to 1893, inclusive, was 1,528, a difference of only 30 from the preceding 8 years. The height of responsibility accepted by the State for the relief of the various communities from the care of State Poor was reached in the next 6 years, during which there was a yearly average of 2,014 State Poor committed to the different almshouses in the State. A general decline in the number of State Poor maintained as proper burdens upon the State is noticeable in the table from this time on.

The average for the next 5 years, from 1900 to 1904, was 1,538. An explanation of the falling off in the commitment of State Poor is given in the report of the Committee on State and Alien Poor, in Vol. I of the Report of the State Board of Charities for 1904, on page 374:

> The commitment of State Poor during the past year has fallen off to some extent, as compared with previous years. The time of maintenance has also been shortened. These two things are due to the rigid inquiries made into the history of all applicants for relief as State Poor persons. Many such have been rejected after primary examination and others after an interview by the agent or inspector of the department.

Although the decline for the years from 1900 to 1904 was marked, it is far less marked than the decline in the 7 years succeeding, 1905 to 1911, during which time the average number committed annually by the State as State Poor was 575. Thus, it will be seen that during the 7 years ending with 1911, 30 years after the State Poor Law went into operation, while the burdens of the municipalities had increased tremendously, the State maintained as charges upon itself an annual average 15 per cent. smaller than it maintained during the first 4 years beginning with 1874.

Not only is this true, but in the 10 years from 1902 to 1911 inclusive there was a marked decrease in the sums paid by the State Board of Charities for the maintenance of State Poor under contract in the almshouses in the State. From Table XLVII it may be learned that this sum diminished from nearly $13,000 in 1902 to less than $5,500 in 1911.

Report of the Superintendent of the State and Alien Poor of the State Board of Charities

The following extract from this report for the year ending September 30, 1911, is found in the Annual Report of the State Board of Charities for 1911, Vol. I., page 287:

> The Superintendent of State and Alien Poor is appointed by the State Board of Charities, under chapter 55 of the Consolidated Laws, which requires him to visit, either in person or by representative, each State almshouse at least once every three months, and to examine into the condition and needs of all State poor persons. It is his further duty to provide, when practicable, for the return to their legal residence of all aliens and non-residents committed as poor persons to public charitable institutions. He has complied with the requirements of the law during the past fiscal year, and made the investigations and inspections regularly.

Another extract from the same volume, on page 285, from the report of the Committee on State and Alien Poor is as follows:

> The inspection of almshouses, public hospitals and similar institutions is an important part of the work, and the Board's inspectors annually visit all such institutions and make careful examination, noting improvements as well as defects. These inspectors also examine such aliens and non-resident poor as may be found in public institutions and in others maintained at public expense and make report thereon to the Superintendent. A careful physical examination, attested by the attending physician, enables the Superintendent to determine whether such dependents are likely to be a permanent charge upon the public or will be able to become self-supporting. In the first instance, unless special reasons suggest different action, the aliens and non-residents are returned to their proper legal residence. In the latter instance, they are discharged to take care of themselves when able to do so. The aliens found are usually reported to the United States Commissioners of Immigration, who, when possible, coöperate with the Department in their removal to foreign lands.

A compilation of the work of the Department of State and Alien Poor for the year ended September 30, 1912, as it affected New York City will be found in Table XLIV. The figures in this table were gathered from the monthly reports of this Department of the State Board of Charities to the Departments of Public Charities and Bellevue and Allied Hospitals. It will be seen from this table that of the total number of 1,353 removals from this City during the year named, 877, or 64.8 per cent., were from the Department of Public Charities; 232, or 17.1 per cent., were from Bellevue and Allied Hospitals; 183, or 13.5 per cent., from numerous private institutions; 21, or 1.6 per cent., were from two State hospitals for the insane; 9, or .7 per cent., were from two hospitals of the Department of Health; and 31, or 2.3 per cent., were from institutions not named in these reports. This Department of the State Board of Charities included in its reports of removals some cases which were actually removed by the United States Immigration Service, to which, however, the attention of the United States authorities was called by the State Board of Charities. These removals by the United States officials totaled 44 during this year, and the majority of these came from the Department of Charities. This number of removals by the United States is very small in comparison with the 688 removals to other countries through the instrumentality of the State Board of Charities. Not greatly behind these removals to other countries by the Department of State and Alien Poor are its removals to other states, which totaled 621 in this fiscal year. The preliminary report of the State Board to the Legislature for the same fiscal year shows that the total removals from the entire State through this Board was 2,024. Over 60 per cent., therefore, of the removals from the entire State were made from New York City.

ALIENS, NON-RESIDENTS, AND STATE POOR IN A MUNICIPAL HOSPITAL

In order to make a test of the dependents in the public charitable institutions of the City it seemed well to select institutions representative of two general classes; namely, hospitals and almshouses. Bellevue Hospital was selected for the examination of its patients, for the purpose of ascertaining, as far as practicable, what aliens, non-residents, and State Poor were maintained and treated at the City's expense.

In the City of New York, in accordance with the general provisions of the Poor Law, it is specifically stated in the section of the Charter dealing with the Department of Public Charities that:

> The Commissioner shall be the overseer of the poor of New York, as constituted by this Act.

While the hospitals now incorporated in the Department of Bellevue and Allied Hospitals were in the Department of Public Charities they and their inmates were under the control of the Commissioner, in his capacity of overseer of the poor of the City. When, however, the Department of Bellevue and Allied Hospitals was formed, the relation of the Commissioner of Public Charities became only that of an *ex-officio* member of the Board of Trustees, and to no official or officials was there given specifically the powers of an overseer of the poor to be exercised in the Department of Bellevue and Allied Hospitals.

Although there has been more or less activity in the Department of Public Charities since its creation toward the relief of the municipality from the maintenance of public charges properly belonging upon some other locality, and many such improper charges have been removed from the City, practically no attention was paid to this matter by the Board of Trustees of Bellevue and Allied Hospitals until the year 1910.

Examination of Records of Bellevue Hospital for 1912

An examination of the records of Bellevue Hospital for the year 1912 showed that a large number of public charges belonging to the three classes of aliens, non-residents, and State poor, had been allowed to enter this institution freely. The comparatively newly aroused interest of the authorities in control was found to have produced results in the removal of a small proportion of the patients treated within this institution in this year; also in the collection of the small sum of approximately a thousand dollars from patients who, had their treatment not been paid for, would otherwise have fallen into one of these three classes of poor persons.

The records of the Hospital show that in this year there were 2,431 admissions of patients who had lived in New York City less than 1 year, and who, therefore, had no established settlement in this City as defined in the Poor Law, and that these patients received 26,297 days of treatment, at a total estimated expense to the City of $47,597.57. Receipts amounting to $1,039 were found to have been taken in by the Hospital in return for the expense of these patients. Of these 2,431 non-residents of the City, 1,426 were aliens, who received treatment for 16,395 days, at an expense of $29,674.95; while 1,005 were citizens, who were treated 9,902 days, at a cost of $17,922.62. (Tables X and XI.)

In addition to the above there were found to have been a considerable number of aliens admitted to the Hospital who had established a settlement in the City but who had been in the United States less than 3 years. Had complete records of the duration of their diseases prior to their admission been available, many of these aliens would doubtless have been found to fall within the classes deportable under the United States Immigration Laws. The histories, however, from which this information was gathered did not give enlightenment on this point. There were 1,308 admissions of alien patients of this class in the year 1912, who received 15,411 days of treatment, at an estimated expense to the City of $27,913.91. (Table XII.)

The above figures give only a partial idea of the expense to the City for the maintenance and treatment of non-resident and alien poor in this institution. With the exception of the few included in the aliens less than 1 year in the City, no account whatever was taken of those aliens who had been in the United States more than 3 years. Many of these unquestionably had not formed permanent associations in this country, and the nature of their sickness would make deportation proper. In a number of these cases such an act would undoubtedly have been the preference of the patients. Nevertheless, of the limited classes considered, there was a combined total of 3,739 patients, maintained for 41,708 days, at a gross estimated expense to the City of $75,511.48. Of this large number there were only 77 patients whose expense was found to have been paid for. The total amount of the payments aggregated $1,039, leaving 3,662 patients whose expense, amounting to $74,472.48, fell entirely upon the City. This amount does include a proportion of the general administration expense of the Department, but contains none of the carrying charges accruing from corporate stock expenditures. (Table XIII.)

The non-residents admitted to the Hospital in this year were, for comparison, separated into two classes; viz., aliens and citizens. The former class seemingly would have less claim upon the public charity of this country than the latter. Under the Charter, specific provision is made for the reception into this Hospital of certain non-residents of the City, as follows:

> TITLE II. Section 692. 7. Any person injured or taken sick in the streets or in any public square or place within The City of New York, who may not be safely removed to his or her home, may be sent to and shall be received by the said hospitals for temporary care and treatment, irrespective of his or her place of residence. The said board of trustees shall provide and maintain suitable rooms or wards for the reception, medical examination and temporary care of persons alleged to be insane.

The two kinds of non-residents received in Bellevue in 1912 were divided in reference to this section of the Charter as follows:

Class I.—Aliens whose admissions were authorized by this section of the Charter. Class II.—Aliens whose admissions were not authorized by this section of the Charter. Class III.—Aliens for whose admissions the authorization by this section of the Charter was not evident. And Classes IV, V, and VI, consisting of similar divisions of the citizens. (Tables IV to IX.)

More than two-thirds of the non-residents admitted were found not to have been brought from some public place or street, as allowed under the Charter. A total of 928 alien non-residents were found not to have been of this class, compared with 420 that were (Tables IV and V), while 626 citizens were not of this class, in comparison with 324 which were

brought in as allowed by the Charter (Tables VII and VIII). There were 78 aliens and 55 citizens, or a total of 133, of whom it was not clear whether they were emergency cases of the character mentioned in the Charter (Tables VI and IX).

It is apparent, therefore, that this expense to the City has not been brought about merely by accidents or other emergencies arising in public places or on the streets. To make this clear, study was made of the methods by which these admissions were made. Of these 2,431 non-resident admissions, 1,148, about which the records gave information on this point, or nearly one-half of the total, were admissions of patients who had come on foot to the institution for treatment (Table XXXII). Of the remainder, 458 were brought in by the ambulances belonging to Bellevue and 518 by ambulances belonging to other hospitals, while in the cases of 230 the means by which the patients reached the Hospital either were unknown or were different from those stated.

As the Charter provides for the reception of non-residents who pay for their treatment in the Hospital, the 77 cases who paid were placed in a class by themselves. An examination of Table XXVIII will show that 1,056 of the total of 1,554 non-residents that were admitted to the Hospital otherwise than as provided for in Section 692, Subd. 7, of the Charter, walked to the door of the institution and were accepted as public charges by the admitting officers.

Careful analysis was made of all of these non-residents with regard to their residence: in the United States, in the cases of aliens, and in New York City, in the cases of citizens. The statements of the patients themselves, as given upon admission, were accepted. It can hardly be questioned that these patients would be much more likely to claim a longer residence in a country or city than they really had, rather than a shorter one. The analysis, therefore, in the tables appended should be an under-estimate rather than an over-estimate.

These non-residents were carefully separated into thirteen classes according to the United States and State laws for admission and deportation of immigrants and the definition of County, State, and Town Poor. Also, a class was made of the patients "Apparently justifiable as City charges." This class consisted of patients for whom payment was made, prisoners, insane cases, and a few others whose ailments seemed to be of a nature which would warrant their being cared for by the City, even though they might not have been brought from the street or some public place.

Non-Resident Aliens

Of the 1,426 non-resident aliens[1] admitted in this year, it was evident from the records that 178 had been improperly admitted to the United States. A few typical cases of this class will be found on pages 133 to 135. From the information given on the admission and discharge records it appeared that 273 more of these aliens were removable by the State Board of Charities. It is more than probable that a number of these cases had been improperly admitted to this country, but the records consulted were not sufficiently full to demonstrate this fact. These two classes had

[1] Here and elsewhere in this Report when a number of persons is said to have been admitted to a City institution the different admissions of the same dependent were counted as separate persons in accordance with institutional practice. The actual number of persons involved may be slightly smaller than the number given.

been given a total of 6,358 days treatment, or 2,769 and 3,589 days, respectively, at a total expense of $11,507.98. (Table X.)

Prominent among the aliens were those patients, not included in other classes, that had been in this State less than 2 months. Applying the legal definition, these patients, according to the Poor Law, would have fallen into the class of State Poor[1] cases. There were 184 such cases, exclusive of those in other classes. A special statement will be found on pages 51 and 52 regarding the patients in the Hospital in this year who had been less than 2 months in the State before their admission.

The proportion of these 1,426 non-resident aliens, exclusive of those in other classes, who had not lived in the United States long enough to gain a settlement was large, totaling 357. The entire number of these non-resident aliens less than 1 year in the United States was 859, 60 per cent. of the alien non-residents, or 35 per cent. of all non-residents admitted in this year. It is apparent, therefore, that a large part of the burden upon the City through the Hospital for the maintenance and care of non-residents comes from the recently landed population.

There were a number of cases, 78 in all, of patients who claimed to have lived long enough in New York State to have gained a settlement, but who had not established a settlement in the City. These were grouped under the division of "county or town cases,"[2] and further subdivided as "county or town cases with New York City address," 29 patients; "county or town cases without New York City address," 29 patients; "county or town cases giving no address," 20 patients. The blank spaces on the history cards, designed to be filled in with information that would clearly establish the legal residence of these patients, were apparently never used in taking the history in the admitting office. It is not possible, therefore, to say where these individuals had their legal settlement. The histories, however, showed a residence of 1 or more years, and, in some cases, of a lifetime in New York State.

There were 22 cases, half of which had been in the United States less than 1 month, for whose expenses a steamship company was apparently properly liable, under the regulations of the Bureau of Immigration and Naturalization of the United States Department of Labor. Also there were 42 aliens who had not been in the State of New York for the period of 1 year necessary for them to establish a residence here. In the case of 73 others, on account of the incompleteness of the records of the Hospital, it was not possible to ascertain in what state these had a settlement. A few cases among these aliens gave addresses outside of the State of New York and claimed to have a settlement in New York City. There were 8 such found during this year. (See Table X.)

Non-Resident Citizens

The non-resident citizens, as shown upon the admission records of the institution, were not so numerous during this year as the non-resident aliens. There were, however, by their own statements, 1,005. But, because

[1] The Hospital records do not show the exact number of days' residence in the case of patients in the State over 1 month and less than 2 months. It has, therefore, been necessary to class as "State Poor" all less than 2 months in the State. Subsequent investigation indicates that the results are an understatement of the actual facts rather than an overstatement.

[2] These cases as referred to here and elsewhere in this Report are not necessarily county or town poor. See (b) Non-Residents of New York City, page 33.

of the results of a supplementary investigation made in a small proportion of the cases, this number is not considered to reflect accurately the total number of such non-residents admitted. As a matter of fact, in many cases where supplementary investigation was made, the admission statements were corrected, and it was found that there was a decided tendency on the part of the patients to exaggerate their length of residence, as well as to make unwarranted statements regarding their citizenship.

Accepting, however, these uncorrected statements of the patients, which show that there were 1,005 non-resident citizens admitted during the year, it was found that these received 9,902 days treatment, at an estimated current expense to the City of $17,922.62. Of this large number of non-residents payments were made for only 50, which amounted to $533. (Table XI.)

Conspicuous among this class of patients were those cases that apparently were removable by the State Board of Charities, there having been 240 during the year. Many of these had been in the City only a very short period of time; 23 were admitted to the Hospital on the day they came to the City; 36 others had been less than 3 days in the City; 14 more less than 1 week; 71 others less than 2 months; and more than half of the remainder less than 6 months.

Another prominent class among the citizens was that of patients who claimed a residence of a considerable period of time in the State of New York, which in some cases covered the entire life, but who had not established a settlement in the City of New York. These aggregated 222 in all, and appear in the same table as "county or town cases." Of these, 117 gave a New York City address, which would indicate, if the address had been their actual residence, that they had had some period of stay within the City. However, investigation proved that not infrequently an address given in such a case was not the residence of the patient, but the address of some relative or friend within the City, or of a temporary lodging house. Among those who gave the City addresses were 4 who had been in the City less than 1 day; 3 more who had been in the City less than 3 days; 11 others who had been in the City less than 1 week; 26 more who had been in the City less than 1 month. Among these 222 patients that were apparently residents of other counties or towns were 92 who did not give a New York City address. Over half of these had been in the City less than 3 days. In the case of 13 of the 222 patients no residence address whatever was given of the patient, but the history cards showed that they had all been in the City for a varying length of time, in no case, however, over 6 months.

Apart from such patients included in the classes already mentioned and in other classes of citizen non-residents, there were 148 who had had less than 2 months' residence in the State of New York, and who were, under the definition of the State Poor Law, State Poor cases. More than one-half of these cases had been in the City less than 1 week before admission to the Hospital, and two-thirds of the remainder had been in the City less than a month. The incompleteness of the records made it difficult to get an accurate idea of the number of these cases within the institution. For example, there were cases in which the records lacked information as to whether these individuals had established a settlement in the State of New York or not, and there were 38 cases of patients who gave residence addresses outside of New York State, although they claimed a settlement

within New York City. This seeming discrepancy remained without correction or confirmation upon the records. A special statement on the State Poor in the Hospital in 1912 will be found on page 140.

Of the 1,005 admissions of non-resident citizens, 69 were patients who had lived less than 1 year within the State of New York (in addition to such included in other classes). Most of the 69 had lived less than 6 months in the City, including a few who had only a few days residence in the City. Another class of cases wherein the admission records possibly contradicted themselves included 22 patients who claimed to have a settlement within New York City but gave addresses in some other locality. There were also among these 1,005 admissions a class that, for humanitarian reasons and legal provisions, seemed justifiable as patients within the Hospital, even though they had not established a settlement within the City. These amounted in all to 80 during the year. The justification for the reception of 50 of these within the Hospital was based upon the fact that they paid for their maintenance, in accordance with the provisions of the Charter, Title II, Section 692, Par. 8, as follows:

> The said board of trustees may permit the reception and treatment in said hospitals of persons who do not reside in the City of New York, provided that every person so receiving treatment shall be required to pay such sum for board and attendance as may be fixed by said board of trustees, and provided that no such person shall be received to the exclusion of patients who reside in said City. . . .

The quotation of this section from the Charter is not, however, to be considered as endorsement of the ability of the Hospital to furnish accommodation to these patients without overcrowding and thereby hampering the facilities for the treatment of residents of the City.

Apparent Contraction of Ailment Before or After Coming to New York City

It is of interest to this community to know whether the dependents it is caring for in municipal hospitals at public expense had the ailments which brought about this dependence before they came to the City, or whether these ailments were contracted subsequently. It is obviously difficult to reach such a conclusion, because of the indefinite character of hospital diagnoses and the consequent inability to determine from this source how long the ailments have been in progress. However, a tabulation was made of the 1,005 non-resident citizens who were admitted to Bellevue Hospital in 1912. This tabulation will be seen in Table XXXVI.

These cases were assembled into 3 classes similar to those in Tables VII, VIII, and IX; namely, Class IV, Citizens whose admissions were authorized by Sec. 692, Subd. 7, of the City Charter; Class V, Citizens whose admissions were not authorized by this same section; Class VI, Citizens for whose admissions the authorization by this section was not evident. Under each one of these classes, and also under the combined total of the three, the cases were divided according to the probable contraction of the ailments of the patients, before and after they came to New York City, with an indefinite subdivision for those cases in which it was impossible to determine from the diagnoses how long the patients had been suffering from their ailments. The division between the cases of ailments contracted before coming to the City and those from ailments contracted after, was made on the basis of the incubation or duration of

the particular ailment that must have preceded its detection as a case needing hospital treatment. In a large number of cases, which in fact totaled slightly over one-half of the non-resident citizens, there was no basis for determining the duration of the disease, consequently these 536 cases had to be placed in the indefinite class. Of this indefinite class, 213 were cases of alcoholism. It is apparent that it is impossible to say how long these patients had been addicted to the use of alcohol without full clinical information on this point, but it was interesting to notice that in the case of over one-third of these 213 alcoholic admissions the patients had been less than 24 hours in the City of New York. The general class of "Causes not otherwise specified," which consisted of 85 cases, was also of cases found to be indefinite; and the traumatisms, burns, and other cases that could have arisen from accidents, and which represented a total of 75 cases, were also included in the indefinite cases. Over one-third of the patients represented by the diagnoses classified as "Causes not otherwise specified," and over one-half of those represented by the diagnoses "Traumatism, burns, etc.," had been in the City less than 24 hours prior to their admission to the Hospital. The next largest class included among these indefinite cases was the insane, or alleged insane, who totaled 73 admissions, over one-half of whom were patients who had been in the City less than 24 hours. The three remaining groups of these indefinite cases were the diseases of the digestive system not specified as chronic, which numbered 56 cases; the 18 cases of hernia; and the 16 pregnancy cases discharged before confinement. Among these three last named groups there were 15 cases of patients in the City less than 24 hours.

Of the 469 cases that it seemed could be safely divided according to the contraction of the ailment before or after coming to the city, 315, or over two-thirds of the total, appeared to have had the ailment before coming to New York City. The majority of these cases were found to fall among the tubercular, cardiac, chronic alcoholic, drug habit, and venereal diseases. Of these 315 cases, 205, or 65 per cent., will be seen by reference to Table XXXVI to have been in Class V, and therefore had not been brought from the street or any public place.

Many of the ailments included in this tabulation as having possibly been contracted after the patients came to New York City probably were in progress before this time, the division having been made on the generous allowance that the ailments had been contracted at the most recent possible date. Also, where the hospital diagnosis did not specify whether an ailment was acute or chronic, it was classed as acute.

Diagnoses of Non-Residents' Cases

The diagnoses of these 2,431 non-residents admitted to Bellevue Hospital in 1912 are significant, as they, to some extent, indicate whether these non-residents were suffering from emergent or chronic conditions, and whether these conditions were of recent or more remote origin at the time of their admission.

The discharge diagnoses for these patients as they were entered upon the records of Bellevue Hospital are shown in Table XXXVII. In this table it will be seen that 22 per cent. of the citizen non-residents were admitted to the Hospital on account of alcoholism and drug habit, and 8 per cent. of the aliens received treatment for the same trouble.

Insane cases formed a considerable proportion of the aliens, having

amounted to 184 cases, or 12.9 per cent. of the total admitted, while the insane formed 7.3 per cent. of the citizens, having amounted to 73 cases.

Tuberculosis of the lungs was a prominent diagnosis, having been the ailment from which 121, or 8.5 per cent., of the total aliens were suffering, and 59 cases, or 5.9 per cent., of the total citizens. Taking pulmonary tuberculosis and other tubercular diseases together, 201 cases of aliens and citizens were afflicted with tuberculosis. Of this number, over two-thirds, or 133, were aliens.

In the venereal and genito-urinary cases, however, the citizens formed the larger proportion, there having been 40 cases of gonorrhea; 36 cases of syphilis; 23 cases of chronic genito-urinary conditions, or a total of 99 cases among the citizens, which formed 9.9 per cent. of the admissions of non-resident citizens, as compared with the 5 cases of gonorrhea; 39 cases of syphilis; 8 cases of chronic genito-urinary ailments, or 52 cases in all among the aliens, which formed 3.8 per cent. of the total admissions of aliens. This made a total of 151 cases of aliens and citizens who had venereal or chronic genito-urinary conditions.

There were 30 cases of epilepsy and other diseases of the nervous system among the aliens, as compared with 24 of the citizens. There were 20 cases of hernia among the aliens, and 18 among the citizens.

In considering the chronic cases not already mentioned it will be seen that there were among the aliens 19 cases of chronic alcoholism; 6 cases of chronic rheumatism; 9 cases of chronic diseases of the respiratory system; 24 cases of chronic diseases of the heart and circulatory system; and 5 of chronic diseases of the digestive system, as compared with 24 cases of chronic alcoholism; 5 cases of chronic rheumatism; 1 case of chronic disease of the respiratory system; 58 cases of chronic diseases of the heart and circulatory system; and 13 cases of chronic diseases of the digestive system among the citizens. These chronic ailments formed a total of 101 cases, or 9.8 per cent. of all the citizens, and 63 cases, or 4.4 per cent. of the total admissions of aliens.

There were more cases of cancers and tumors among the aliens than among the citizens, these having been 13 and 5, respectively. Typhoid fever claimed 7 cases among the aliens, as compared with 1 case among the citizens. Other epidemic diseases were represented in 13 cases among the citizens, and none among the aliens. Malaria claimed 20 aliens and 15 citizens; and the parturition and pregnancy cases amounted to 61 among the aliens, and 48 among the citizens. The non-residents admitted for erysipelas and cellulitis were entirely among the aliens, and formed a total of 87 cases, or 6 per cent. of their total admissions.

In the acute diseases, in which are classed all diseases not shown on the records to be chronic, the aliens were more heavily represented than the citizens. There were 46 cases of rheumatism, as compared with 12 among the citizens; 77 cases of acute diseases of the male genital organs, as compared with 24 among the citizens; 18 cases of female genital organs, as compared with 9 among the citizens. The acute diseases of the nervous system, however, formed only 2 cases among the aliens, as compared with 15 among the citizens. There were 69 cases of acute diseases of the respiratory system among the aliens, as compared with 22 among the citizens, and the 9 cases of aliens admitted for acute diseases of the heart and circulatory system were equaled by those of citizens. The cases admitted for acute diseases of the digestive system numbered 101 aliens and 76 citizens.

Under "Causes not elsewhere specified," which were miscellaneous

cases, there were 154 cases of aliens and 85 cases of citizens, while the accident cases classed as "Traumatism, burns, etc.," embraced 163 cases of aliens and 75 cases of citizens.

Illustrative Cases

Extracts from a few histories of the aliens, non-residents, and State Poor are given here, under the same classes and subdivisions employed in the tables already referred to. (Tables IV to XXXIII.)

Class I-1. Apparently Improperly Admitted to the United States.

A native of Portugal. Age 32 years. Single. Occupation, sailor. This patient was in the employ of a steamship company and had been in the United States only 2 days. He was brought to the Hospital by the Bellevue ambulance, with a venereal disease impossible to have originated since his admission to this country. He remained in the Hospital 4 days as a free patient.

A native of Canada. Age 35 years. Single. Occupation, domestic. This patient had been in the United States only 6 weeks when she was brought to the Hospital by the Bellevue ambulance. She had chronic pulmonary tuberculosis, unlikely to have originated since her admission to the United States. She was in the Hospital 4 days, and was discharged, not removed for deportation.

Class I-3. Apparently Removable by State Board of Charities.

This patient was a native of Italy, who had been in the United States 14 months, and in New York only 2 days. He was brought to the Hospital by an ambulance not belonging to Bellevue, with pulmonary tuberculosis. He remained in the Hospital 5 days as a free patient and was transferred from there to another City hospital.

A native of Italy. Married. Occupation, shoemaker. This patient had been in the country 7 months, and in New York City only 4 days. He was brought to the Hospital by the Bellevue ambulance from a private residence. He remained in the Hospital 7 days as a free patient and was then transferred to another City hospital, with a diagnosis of chronic pulmonary tuberculosis.

Class I-4. Apparently Removable by State Board of Alienists.

A native of Russia. Age 25 years. Single. No occupation. This patient had been in the United States only 10 months when he was brought to the Hospital by the Bellevue ambulance. He had delusions of persecution and had been threatening to kill every one, according to his admission history. He had refused to work, continually claiming to be sick. He remained in the Hospital for 4 days as a free patient and was then discharged in charge of relatives.

A native of West Indies. Age 19 years. Colored. Single. Occupation, servant. This patient had been in the United States 10 months and in New York City only 2 months when she came to the Hospital. She remained in the Hospital 3 days as a free patient and was then transferred to a State hospital for insane.

Class I-5. Apparently County or Town Case.

A native of Ireland. Age 30 years. Single. Occupation, orderly. This patient claimed 10 years residence in New York State but only 1 day in New York City when brought to the Hospital by an ambulance not belonging to Bellevue. He had sciatica and remained in the Hospital 11 days as a free patient. He was then transferred to another City hospital.

Class II-1 and 2. Apparently Improperly Admitted to the United States and Deportable by the United States.

A native of Russia. Age 26 years. This patient had been in the United States only 8 days when admitted to Bellevue Hospital. He had chronic pulmonary tuberculosis, impossible to have originated since his admission to this country. He

was in the Hospital 11 days as a free patient and was then transferred to another City hospital.

A native of France. Age 30 years. Married. Occupation, waiter. This patient had been in the United States 3½ months and in New York City for 1 month when admitted to Bellevue Hospital. He died of pulmonary tuberculosis after 10 days in the Hospital as a free patient.

Class II-3. Apparently Removable by State Board of Charities.

A native of Turkey. Age 22 years. Single. Occupation, diamond cutter. This patient had been in the United States only 4 months when admitted. He was in the Hospital 7 days as a free patient, with chronic articular rheumatism, and also a venereal disease. He was then discharged and not removed for deportation.

A native of Finland. Age 35 years. Single. This patient had been in the United States 3 months when admitted to Bellevue Hospital. He was in the Hospital 6 days as a free patient, with chronic alcoholism and delirium tremens. He was discharged and not removed for deportation.

Class II-4. Apparently Removable by State Board of Alienists.

A native of Poland. Age 25 years. Occupation, laborer. This patient had been in the United States only 6 months when brought to the Hospital by an ambulance not belonging to Bellevue. He was insane and had erysipelas, and after 74 days in Bellevue as a free patient he was transferred to a State hospital for insane.

A native of Ireland. Age 22 years. Single. No occupation. This patient had been in the United States only 2 months when admitted to Bellevue Hospital. He was in the Hospital 9 days as a free patient. He was transferred as insane to a State hospital for insane.

Class II-5. Apparently County or Town Cases.[1]

A native of Hungary. Age 42 years. Married. Occupation, cooper. This patient had been in New York State 1 year but in New York City only 8 days when admitted to Bellevue Hospital. He had pneumonia and simple anemia, and remained in the Hospital 29 days as a free patient.

A native of Greece. Age 22 years. Single. Occupation, waiter. When admitted to Bellevue Hospital this patient had been in the United States and in New York State 2 years, and in New York City only 2 days. He had an inguinal hernia and was in the Hospital 17 days as a free patient.

Class II-7. Apparently Charges of Steamship Company.

A native of England. Age 36 years. Occupation, steward on a steamship. This patient had been in New York City only 2 weeks when brought to the Hospital by an ambulance not belonging to Bellevue. He had chronic pulmonary tuberculosis and died after 4 days in the Hospital as a free patient.

Class IV-3. Apparently Removable by State Board of Charities.

A native of the United States. Age 20 years. Occupation, laborer. This patient had been in the State of New York only 2 weeks when brought to the Hospital by an ambulance not belonging to Bellevue. He had morphine poisoning and remained in the Hospital 13 days as a free patient. His own address and those given for relatives were all outside the State. He was discharged and not removed by the State Board of Charities.

A native of the United States, who gave an address outside New York State. He was brought to the Hospital by an ambulance and remained there 5 days as a free patient. He was not removed by the State Board of Charities, and was discharged with a diagnosis of arteriosclerosis and chronic nephritis.

Class IV-4. Apparently Removable by State Board of Alienists.

A native of the United States. Age 31 years. Married. This patient gave an address outside New York State, and had been in New York City only 3 days

[1] See footnote 2 on page 40.

when admitted to Bellevue. He was in the Hospital 5 days as a free patient and was then transferred to a State hospital for insane.

A native of the United States. Age 35 years. Widower. Occupation, machinist. When admitted to Bellevue this patient had been in New York State only 1 day. He was in the Hospital 4 days as a free patient and was then transferred to a State hospital for insane.

Class IV-5. Apparently County or Town Cases.

A native of the United States. Age 21 years. Single. This patient had been all his life in New York State but only 4 months in New York City when admitted to Bellevue. He came to the Hospital with a diagnosis of chronic nephritis and acute mania, and remained there 5 days as a free patient.

Class V-3. Apparently Removable by State Board of Charities.

A native of the United States. Age 35 years. Single. Occupation, driver. This patient had been only 4 months in New York State when admitted to the Hospital. He had chronic pulmonary tuberculosis. After 4 days in Bellevue as a free patient he was transferred to another City hospital. The address given for relatives was outside New York State.

A native of the United States. Age 33 years. Occupation, stenographer. This patient had been in New York State 8 months when admitted to Bellevue. He remained 2 days in the Hospital as a free patient and was then discharged, with a diagnosis of chronic morphine poisoning and multiple abscesses. He was not removed by the State Board of Charities.

Class V-4. Apparently Removable by State Board of Alienists.

A native of the United States. Age 38 years. Single. Occupation, cook. This patient had been in New York State only 1 week when admitted to Bellevue. He remained in the Hospital 21 days as a free patient and was then transferred to a State hospital for insane.

A native of the United States. Age 38 years. Married. This patient had been in New York State 2 months when admitted to Bellevue. She remained in the Hospital 12 days as a free patient and was then transferred to a State hospital for insane.

Class V-5. Apparently County or Town Cases.

A native of the United States. Age 25 years. Single. Occupation, printer. This patient had been in New York City only 4 days when admitted to Bellevue. He remained in the Hospital 2 days as a free patient and was then discharged, with a diagnosis of cocaine poisoning. The address given for relatives was outside New York State.

A native of the United States. Single. Occupation, laborer. This patient had been in New York City only 1 day and claimed life-time residence in New York State when admitted to Bellevue. He had a cyst infection and remained in the Hospital 6 days as a free patient.

Means of Relief

(a) *Removal by the United States Immigration Service*

The different agencies of relief of charitable institutions from the burden of alien and non-resident dependents have already been discussed in this report (pages 117 to 120). The operation of these agencies in Bellevue Hospital was made an object of study. Prior to the last 2 or 3 years there seemed to have been only an occasional removal from the Hospital of aliens improperly within the country. The awakened interest of the Board of Trustees in the last few years, however, has resulted in increased activity in this direction.

The ordinary process for the removal of these aliens has been as follows:

The Department of State and Alien Poor of the State Board of Charities is notified of the presence of deportable aliens in the Hospital as patients; an inspector is then sent out from the office of this Department of the State Board to examine such of this class of patients as he may be able. This visit of the inspector may be either preceded or followed by a request upon the authorities of the Hospital from the branch office in New York City of this Department or from the head office in Albany, that this alleged alien be detained by these authorities pending investigation into the propriety of his removal. In cases where the information supplied to the State Board seems to indicate strongly that these aliens should be deported, this "holding notice" not uncommonly precedes the inspector's visit. The report of the inspector is then made to the Deputy Superintendent of the Department of State and Alien Poor in New York City, and, if in his opinion the facts justify such action, this report is forwarded to Albany to the Superintendent of the Department, without whose approval, it is understood, no deportations are made. If the information given to the Superintendent seems to him to justify such a course, he may seek to confirm the time of landing of such an alien by a letter of inquiry to the Commissioner of Immigration at Ellis Island. On account of the possible discrepancies in name, and other confusing factors, the landing may not be confirmed on first inquiry. Should, however, this landing be confirmed, and the case be turned over to the United States Government for deportation in conformity with the provisions of the law quoted on page 117, a United States Immigration Inspector may be sent out from Ellis Island to see the alleged alien and confirm the facts submitted as grounds for his removal. When the authorities at Ellis Island are satisfied that an alien falls within the provisions of the law authorizing removal, a statement of the case is forwarded to the Department of Labor in Washington, from which place, upon the approval of the authorities there, a warrant may be issued for the arrest of such an alien, that he may be returned to the country from which he came. It is quite apparent that this process is exposed to considerable delay. The State Board of Charities may shorten the process by making the removal of these aliens through their own agents, provided the Board has sufficient funds for that purpose, instead of referring the matter to Ellis Island.

In the year 1912, 181 aliens were admitted to Bellevue Hospital who appeared by the records to have been either improperly admitted to the United States or to have been deportable by the Federal Government (Table XIII). This number is not considered to be more than suggestive, because it was possible, on account of omissions in the histories from which this information was gathered, to include in this class only those recent arrivals in the United States who had ailments of such a character that it seemed impossible that they had been contracted since landing in this country.

It is more than probable that, of the 273 aliens who had been in New York City less than 1 year that were apparently removable by the State Board of Charities (Table X), and of the 513 aliens apparently subject to removal by the same Board that had been in the United States more than 1 year and less than 3 years (Table XII), there was a large proportion of persons, who, if their histories could be traced out, would be found to have had some physical disability or disqualification at the time of their admission to this country which would have justified their being refused admission.

The same might be said of the mentally unbalanced, apparently removable by the State Board of Alienists, of whom there were 160 who had lived in the City for less than 1 year, and 100 who had been in this country more than 1 year and less than 3 years. (Tables X and XII.)

In the case of those aliens for whose arrest a warrant is issued by the Secretary of Labor, payment for maintenance is supposed to be made by the Government, from funds available for that purpose. When, however, the process of removal of these cases, which has been described, is taken into consideration, and also the fact that the Government makes no payment for the time the alien has been in the Hospital prior to the date of the issuance of the warrant, it is evident that even in those cases for which payment is made the remuneration by no means meets the expense to the City. Reference to Tables X and XIII shows that the expense to the City of 181 cases that were either removed by the United States officials, or apparently should have been removed by them in 1912, was $5,020.94, merely for the current expenses at the institution. The total receipts from all sources for these patients during this year was only $187.50. While it is possible that the Government might not feel the necessity of the deportation of a few of these cases, it is evident that this discrepancy is too large to be disregarded.

The records of the Hospital do not show that more than 8 of these cases were removed, and the monthly reports of the State Board of Charities show only 5 removals from this institution by United States officials during the entire year of 1912. When this is compared with the statements made in the Annual Reports of the Department of Public Charities for the years 1902, 1903, 1904, and 1905, of the aliens returned by this Department to the Commissioners of Immigration, it will be seen that there must have been a much more effective coöperation between the Department of Charities and the immigration authorities in those years than now exists between the Board of Trustees of Bellevue Hospital and the same authorities. The figures in these Annual Reports show that in the year 1902, 1,137 aliens were returned to the Commissioner of Immigration; in 1903 there were 861; in 1904, 328; and in 1905, 43. (Table II.)

After the year 1905 these Reports contained no record of the return of any aliens by the Department of Public Charities to the Commissioners of Immigration. On January 15, 1906, a general order was issued by the Commissioner of Public Charities, Robert W. Hebberd, by which the heads of the institutions of the Department were instructed to report all State, alien, and non-resident poor to the Department of State and Alien Poor of the State Board of Charities. It is upon this Department of State and Alien Poor of the State Board that Bellevue Hospital is depending to-day for the removal of aliens who are likely to become prolonged or chronic dependents.

(b) *Removal by the State Board of Charities*

Of the 2,431 admissions of non-residents of New York City to Bellevue in 1912, the records for 2,011 gave indications as to the length of their residence in New York State, and 420 lacked such information (Table XXXIV). Of these 2,011 cases, 1,707, or 85 per cent., appeared from the records not to have been legal residents of New York State, while 304, or 15 per cent., had been in the State 1 year and over. If we extend the proportion of those in the 2,011 classified cases who had been in the State less

than a year to the 420 that could not be classified, there would have been 2,064 admissions in Bellevue Hospital during the year 1912 classed as non-residents of the State.

Of the 1,707 admissions of apparent non-residents of the State, 1,178, or 69 per cent. of the total number classified, were aliens, while 529, or 31 per cent., were citizen non-residents of the State. Of the aliens classified for residence, however, 93.8 per cent. had been in the State less than 1 year, and of the citizens 70.1 per cent. Extending these proportions to the 170 cases of aliens whose time in the State was not indicated, and the 250 cases of citizens, there would have been 1,288 admissions classed as alien non-residents of New York State, and 550 admissions classed as citizen non-residents in Bellevue Hospital in 1912.

Of the alien non-residents of the State, 773, or 65.6 per cent., were not emergent ambulance or alleged insane cases admitted to the Hospital. There were also 319 admissions of citizens, or 60.3 per cent., who were not residents of the State and who were not emergent or psychopathic cases. (Tables V, VIII, and XXXIV.)

The total expense of alien patients admitted whom the records indicated were non-residents of the State, plus a similar proportion of those whose residence was not indicated by the records, was $27,235.30. The expense of the Hospital care of all citizen non-residents for the year was estimated to be $9,688.40, making the total expense of the estimated number of alien and citizen non-residents admitted $36,923.70.

In defrayment of the expenses of these patients, there was paid to the Hospital the sums of $288 for aliens and $182 for citizens, making a total of $470 received.

The total removals of non-residents of the City in this year was 122, according to the Bellevue records, and 105 of these were discharged to the State Board of Charities; 11 to the Federal Government; and 6 to the State Board of Alienists (Table XXXIII). Thus, it will be seen that the total of these non-resident removals by the State Board of Charities constituted an inconsiderable proportion of the total number of admissions. Also, less than 15 per cent. of those whom the records appeared to indicate might properly have been removed by the United States Government or by the State Board of Charities were taken from the institution.

Of the 1,308 admissions of aliens who had been in the United States more than 1 year and less than 3 years, there were 3 cases apparently deportable by the United States Government (Table XII) which were removed by the United States Immigration Service; and of 513 of these cases apparently removable by the State Board of Charities, 36 were removed by this agency, according to the Hospital records. Also, there were 100 cases, apparently proper subjects for removal by the State Board of Alienists, whose removals are usually effected after commitment to State hospitals. According to the monthly reports of removals by the State Board of Charities, the State Board of Charities removed only 7 per cent. of the aliens more than 1 year and less than 3 years in the United States that the records indicated might have been removed.

Of the total of 2,431 non-residents, 60 per cent. were allowed to leave the institution by ordinary discharge. Many cases that were referred to the Department of State and Alien Poor for investigation and possible removal were discharged or transferred from this institution without having been investigated by the inspectors of this Department.

For example, in the month of April, 1911, out of a total of 354 cases in

the hands of the Department of State and Alien Poor of the State Board of Charities which had been referred to them from Bellevue, 52 were removed from Bellevue or institutions to which they had been transferred from Bellevue, while 172 had been allowed to leave Bellevue Hospital without being subjected to any examination on the part of the inspectors of the Department of State and Alien Poor, and on May 1, 1911, there were 130 cases pending in the hands of the same Department. In May, 1911, from a total of 388 cases, there were 21 removals from Bellevue and other institutions of patients reported for investigation, while 179 of this number had not been examined.

(c) *Removal by the State Board of Alienists*

A few cases, 6 in all, of which 2 were of aliens and 4 were of citizens, were removed from Bellevue Hospital during the year by the State Board of Alienists, according to the general records of the Hospital. This Board has been actively at work relieving the State of the maintenance of aliens in the State hospitals for the insane. There were 201 cases in Bellevue Hospital in the year 1912 that seemingly would have properly come within their jurisdiction in this respect. Over 70 per cent. of these were transferred to institutions for the care of the insane, where they were still subject to removal by this Board. (Table XXXIII.)

(d) *Relief from Non-Residents of New York City*

At the time when Bellevue and the allied hospitals formed integral parts of the Department of Public Charities, it was within the power of the Commissioner of Charities to serve notice upon the overseers of the poor of the town or city within the State from which poor persons had come to seek relief in New York City, that they would be expected to pay for the expense of such poor persons in these hospitals and the other institutions of the Department of Charities. Unless the authorities receiving this notice should deny that their town or county was liable for the support of this person within 30 days after the receipt of this notice, the law precluded them from protesting it, and they became liable for this expense.

The medical facilities afforded by the City of New York have drawn many people from other localities within, as well as without, the State, to receive free treatment here. In the year 1912, of 2,431 admissions of non-residents of the City to Bellevue Hospital, the records indicated that 529 patients, or 21.8 per cent. of the whole, had been in New York City less than 24 hours; that 641, or 26.4 per cent., had been in the City less than 3 days; 810, or 33.3 per cent., less than 1 week; and 1,161, or 47.7 per cent. of the total, were patients who had been in the City less than 1 month; 58.4 per cent. were patients who had been in the City less than 2 months, while 2,082, or 85.6 per cent. of the non-residents admitted to Bellevue in 1912, according to their records, had been in the City less than 6 months. (Table XXXV.)

No request was made on the part of the Board of Trustees of Bellevue and Allied Hospitals to the county superintendents of the poor within whose jurisdiction patients had established settlements to reimburse the City for the expense of their medical care and maintenance in Bellevue Hospital, or to remove chronic patients from the Hospital. Neither was any request made to the Department of Public Charities to make such a demand upon these authorities in behalf of Bellevue.

(*e*) *Maintenance of State Poor*

During the year 1912 there were received into Bellevue Hospital 802 patients, of whom more than one-half were aliens, whom the records show had had less than a 2 months residence in the State of New York before admission. Of these patients, 39 had had some payment made toward the expense of their maintenance in the Hospital, the amount having been $470.00. The remaining 763 patients, however, were maintained as public charges upon the City of New York, at a current expense of $13,283.59, without any reimbursement, although, under the definition of the Poor Law, quoted in this report, they were State Poor (Table XXXIV). These 763 admissions formed 38 per cent. of the 2,011 patients non-resident in New York City whose time of stay in the State was indicated. There were, however, 420 patients who were also non-residents of New York City but for whom the length of stay in the State was not recorded. If 38 per cent. of these also had been included with those who were less than 2 months in the City there would have been a total of 962 admissions of State Poor patients, maintained at an estimated expense to New York City of $16,799.39.

Although such a large proportion of the non-residents in this Hospital were State Poor, it would unquestionably have been impracticable to have admitted all of them directly to even the nearest State Almshouse, which is the City Home on Blackwell's Island. Only a small proportion of them were transferred to this Home upon leaving Bellevue.

Upon the State Register at this City Home are entered the names of 126 individuals for whose maintenance it was said bills had been rendered to the State Board of Charities in accordance with the contract between that Board and the Department of Public Charities. Analysis of the records of these 126 poor persons shows that more than two-thirds of them had been inmates of hospitals and institutions other than the City Home, and that 2 of them had been patients in Bellevue Hospital. (Table LII.)

No request was made by the Board of Trustees of Bellevue and Allied Hospitals upon the State Board of Charities to reimburse the City for the expense of any of these persons, nor did these Trustees make any such request through the Commissioner of Public Charities.

Medical and Lay Examination of Patients Admitted to Bellevue Hospital in 1913

Although the study of the records of Bellevue Hospital for 1912, already discussed at length in this Report, was made very carefully, and, it is believed, fairly, these records were not supplemented by a direct investigation of the patients involved. Believing that such an investigation would be of great value in discovering the sources of the burden upon the City's charity, an examination was made, as far as practicable, of every patient admitted to Bellevue Hospital from May 19, 1913, to June 18, 1913, inclusive.

The total number of patients admitted during this period was 3,454, according to the Hospital records. The Committee investigated 3,451 cases, which was practically the same number. Consequently, the Hospital's number was accepted, and 3 cases were added to the Committee's number and counted among the histories in which clear data was not obtained. (Table XXXVIII.)

The examination was carried on by the investigators and physicians in the service of this Committee. The lay investigators examined every patient possible that was admitted to the wards of the Hospital during this period. When the lay investigators discovered patients that were aliens or non-residents of New York City, the cases were referred to the medical examiners of the Committee, who followed them up with direct physical examination of the patients and a careful study of their medical records in the Hospital. As the investigation was not carried outside of the gates of the institution, it was found impossible to obtain sufficient information to determine the citizenship and residence of every patient admitted. A certain number of patients died before full information could be secured from them, and it was not feasible to see their friends or relatives at the Hospital. Also, in a good many cases the subsequent examination of the medical examiners could not be made before the discharge or transfer of the patients who had been seen by the lay examiners, as this Committee refrained, as far as possible, from interrupting the work of the Hospital. In certain of the psychopathic cases, for very evident reasons, the history could not be completed at the Hospital. On account of the advanced or immature age of other patients, complete histories of their cases could not be secured within the Hospital, although every effort was made to interview relatives and friends upon their visits.

Consequently, in these 3,454 admissions there were 635 cases in which the histories could not be completed sufficiently for a positive statement to be made that these patients were aliens, citizens, or non-residents of New York City, or that they were dependent from causes existing prior or subsequent to their entrance into the country or City. In the effort to give a perfectly sound statement, all cases with incomplete histories were rigidly excluded from those classified according to the propriety or impropriety of their dependence at municipal expense.

Every care was exercised to conduct this examination under as nearly normal conditions as possible. The lay and medical examiners of the Committee did not tell the patients under examination of the purpose of their inquiries, and no encouragement was given any of the patients to state that they were aliens with the hope of their being returned to other countries. It is assumed that the patients had no knowledge but that they were being examined by the regular employees associated with the Hospital, although this statement was not made to them. As a matter of fact, though every effort was made to conduct this investigation with as undisturbed conditions as possible, it is believed that the findings of this Committee will show proportions of aliens and of non-residents of the City below what normally exists in the Hospital, because in spite of the efforts of the examiners to avoid such an occurrence there was found to be an increasing reluctance on the part of the patients toward the latter part of the investigation to admit that they were aliens or non-residents of the City.

Citizens

The findings of the Committee will be found tabulated in Tables XXXVIII to XLI. It may be seen that, of the 2,819 admissions of patients for which a sufficiently complete history was obtained to admit of their classification, 1,793, or 63.6 per cent., were patients who claimed citizenship in this country and also a residence in New York City of a year's duration. No effort was made on the part of this Committee to disprove their claims by investigation outside of the Hospital. Also, 164 patients, or 5.8 per cent. of the 2,819, professed to be citizens of this country, although not legal residents of New York City. This would make a total of 1,957 patients who claimed United States citizenship.

The admission records of Bellevue Hospital show that for this period of 31 days covered by the examination, the 3,454 admissions were divided as follows: 1,726 born in the United States; 1,707 born in foreign countries; and 21 whose nativity was unknown. Thus, it will be seen that the proportion of foreign born, according to the records of the Hospital, is much lower than the proportion of patients who claimed to be citizens of the United States when under investigation.

Aliens

There were 862 cases of patients examined by the Committee who acknowledged their foreign birth and that they had not acquired citizenship in the United States (Table XXXVIII). A thorough examination of these patients regarding their social conditions by a lay investigator, and of their previous medical history by physicians who determined their physical diagnosis and prognosis, made possible their classification as appears in Tables XXXVIII to XLI.

A digest of the histories of all aliens of this class whose deportation seemed to be warranted will be found in the Appendix attached to this Report. There were, as may be seen in Table XXXVIII, 383 deportable aliens, comprising 13.6 per cent. of the total cases classified by the Committee.

These 383 deportable aliens were classified as follows: Aliens in the United States in violation of the Federal Immigration Law, 40; aliens de-

portable under the Federal Immigration Law, 63; aliens deportable under the New York State Charities Law, 213; aliens deportable under the State Insanity Law with the consent of responsible relatives or friends, 67. No effort was made by the examiners to obtain the consent mentioned in connection with the last class.

These 383 aliens received 4,144 days of treatment in Bellevue Hospital prior to September 9, 1913, at an estimated expense to the City of $7,500.64. This expense includes a proportion of the general administrative expense of the Department, but does not include any charge accruing from purchase of grounds, construction or equipment of buildings, etc. The only money received by the Hospital up to September 1, 1913, in payment of the expense of these 383 aliens was the sum of $16.50, paid for 1 patient.

A large number of aliens was found in the Hospital whose removal might not have been a humane act because of the presence of near relatives in this country, or their lack of such in Europe, or because their dependence seemed likely to be of a temporary nature. These appear in Table XXXVIII, in Class I, subdivisions 5a and 5b. There were 479 such aliens among the admissions to the Hospital in the 31 days, forming 17 per cent. of the total patients for whom complete histories were obtained by the examiners.

These 479 aliens were divided into two classes: those whose histories strongly indicated that they would become chronic or recurrent dependents upon the City, consisting of 142 cases, and those whose dependence upon the City seemed likely to be temporary, of whom there were 337 cases. The total days of stay of the 142 aliens that were apparently chronic or recurrent dependents was 1,402, at an expense of $2,537.62. The 337 whose dependence seemed likely to be temporary remained in the Hospital an aggregate of 4,443 days, at an expense of $8,041.83. For 4 of this latter class of patients, there was received by the Hospital the sum of $102.50. The total days of stay, therefore, of those aliens whose deportation might have been a matter of debate was 5,845, and their maintenance cost $10,579.45, with total receipts of only $102.50.

In Summary B, Table XXXVIII, is shown the total number of aliens admitted to the Hospital in 31 days. There were 862 such patients, with an aggregate of 9,989 days of stay, at an expense to the City of $18,080.09, up to September 9, 1913. Of this total number of patients, payments were made for but 5, amounting to only $119. These figures, however, are for only those cases in which the histories could be completed. There were 635 cases of incomplete histories, or 22.5 per cent., in the total number of 3,454 admissions in the month. To reach an estimate of the total expense of aliens during the year it is assumed that there would have been the same proportions of these 635 aliens falling into the different classes described, in each month of the year. The total admissions for the month, 3,454, approximated the average monthly admissions for the year 1912.

On the basis of this showing of the period of 31 days there would be received into Bellevue Hospital in a year 12,671 alien patients, whose maintenance would cost the City $265,777.33. If the Hospital received the same proportionate amount monthly, and this amount were deducted from the expense, the net annual cost to the City for the support of alien patients in this one institution would be $264,027.96, exclusive of the cost connected with the erection and equipment of buildings and the purchase of site.

On the basis of the proportion found to exist within a period of 31

days in the cases with histories sufficiently complete to classify there would be received in this Hospital annually as follows:

A total of

588	aliens whose presence in the United States would constitute a violation of the Federal Immigration Law, whose maintenance would cost the City	$14,474.21
926	additional aliens deportable from this country under the Federal Immigration Law, whose maintenance would cost the City	19,769.00
3,131	aliens deportable under the State Charities Law, whose maintenance would cost the City	65,799.11
985	aliens deportable (with consent) under the State Insanity Law, whose maintenance would cost the City	10,217.09

Making a total number of

5,630	aliens, removable under the Federal and State Laws, whose maintenance would cost the City	$110,259.41

Also, there would be

7,041	aliens whose deportation might not have been proper, but whose maintenance would cost the City	155,517.92

As will be seen in the cumulative totals of aliens, in Table XXXVIII, among the 862 alien patients admitted in 31 days there was 1 who had been in the United States less than 1 day; 5 less than 3 days; 8 less than 1 week; 21 less than 1 month; 33 less than 2 months; 64 less than 6 months; 119 less than 1 year; 251 less than 3 years; and 363 less than 5 years.

Of the total of 383 deportable aliens, 1 had been in the United States less than 1 day; 5 less than 3 days; 7 less than 1 week; 14 less than 1 month; 23 less than 2 months; 42 less than 6 months; 76 less than 1 year; 142 less than 3 years; and 208 less than 5 years.

Of the total alien patients 29.2 per cent. had been in the United States less than 3 years; 42.1 per cent. less than 5 years. It is assumed that for a year the number of patients admitted who had been in the United States for the same periods would be twelve times as many as those during these 31 days.

While it is interesting to know that 862 aliens were admitted to Bellevue Hospital in 31 days whose maintenance cost the City $18,080.09, it would perhaps be a matter of even greater interest to know the expense of the alien patients in the United States less than a year, as within this period the expense of the aliens deported by consent and of those who have become public charges from causes existing prior to landing may be paid out of the United States "immigration fund." A showing of the total days of stay of all aliens found to have been in the United States less than 1 year that were admitted to the Hospital within the period of 31 days, will be found in Table XXXIX. In this table there appears also the total number of aliens who had been in the United States under 3 years, the period within which aliens may be deported under the Federal Immigration Law, whose expense, after the date of the issuance of their warrant for deportation, can be paid out of the United States "immigration fund."

In the same table, also, appears the total number of alien patients admitted to the Hospital during these 31 days who had been less than 5 years in the United States; their aggregate days of stay up to September 9, 1913;

and the total expense to that date. Under the application of the former State Emigration Law the expenses of all such aliens might have been paid for out of the funds of the State Commissioners of Emigration, either in the institutions under their supervision, or in other institutions.

The estimated total number of days of stay and expense for each of these groups of patients for a period of 1 year, on the basis of the showing of the cases that could be classified for 31 days, will also be found in this table.

Aliens in the United States Less Than One Year

There were admitted to Bellevue Hospital 119 aliens, in the period of 31 days covered by the examination, who had been in this country less than a year. These remained in the Hospital 1,364 days, at an expense to the City of $2,468.84. On the basis of this showing for 1 month the estimated total number of this class of aliens admitted to the Hospital in a year would be 1,749, and their days of stay 20,051, at an expense to the City of $36,291.95.

Of these 119 aliens found to have been in this country less than a year 76 were deportable. They had been in the Hospital 854 days, at an expense of $1,545.74. Also, there were 43 whose deportation might not have been justified, who remained in the Hospital 510 days, at an expense of $923.10. It will be observed that the number of aliens among those in the country less than a year, who were deportable, was nearly twice as large as those who might not justifiably be deportable.

The number for 1 year of those deportable would be 1,117 aliens, as compared with 632 not deportable, and the expense for deportable aliens would be $22,722.38, as compared with $13,569.57 for those whose deportation might not have been humane. No reference has been made in this connection to the money received by the City for any of these patients, because the total amount of $119 received for all aliens, which has already been mentioned, is too insignificant to deserve consideration.

Of these 119 aliens found to have been in this country less than 1 year, 3 had been removed by the State Board of Charities, and none by the United States Government, prior to September 1, 1913, according to the monthly report of removals of the State Board of Charities.

Aliens in the United States Less Than Three Years

There were 251 aliens admitted in the period of examination who had been in this country less than 3 years (inclusive of those who had been in the country less than 1 year). These remained in the Hospital 3,168 days, at a total expense of $5,734.08 for their hospital care. The proportion for a year would be 3,690 such aliens, remaining 46,570 days, at an expense to the City of $84,290.98. According to the facts gathered 142 of these aliens were deportable. These had been in the Hospital 1,788 days, at an expense of $3,236.28. In comparison with this there were 109 aliens whose deportation might not have been humane, who had been in the Hospital 1,380 days, at an expense of $2,497.80.

The total number in the class of deportable aliens for a year on the basis of this showing would be 2,087, whose maintenance would cost the City $47,573.32; and there would be 1,602 aliens whose deportation might not have been justified but whose maintenance would cost the City $36,-

717.66. Practically nothing was received by the City for the expense of any of these aliens prior to September 1, 1913. Of the 251 aliens found to have been in this country less than 3 years, 4 had been removed by the State Board of Charities, and none by the United States Immigration Service, according to the monthly reports of the State Board of Charities.

Aliens in the United States Less Than Five Years

There were 363 aliens admitted in the 31 days who had been in the United States less than 5 years (inclusive of those here less than 3 years). The aggregate days of stay of these patients prior to September 9, 1913, was 4,284, at an expense of $7,754.04. The estimated number for a year would be 5,336 aliens, with 62,975 days of hospital maintenance, at an expense of $113,984.39.

These admissions may be divided as follows: 208 deportable aliens maintained at an expense of $4,164.81, and 155 aliens whose deportation is not recommended maintained at an expense of $3,589.23. The annual number of those deportable would be 3,058, and their annual expenses $61,222.71; in comparison with the annual number of 2,279 aliens whose deportation would be of doubtful advisability, treated at an annual expense of $52,761.68. Practically nothing was paid to the City for these aliens. Of the aliens found to have been in this country less than 5 years, 5 were removed by the State Board of Charities, and none were removed by the United States Immigration Service.

This indicates that the City is bearing an expense of $113,984 annually for the maintenance in this one hospital of aliens who have been in the country less than 5 years, exclusive of the burden for the erection of buildings, acquisition of grounds, and kindred expenses. Under the provisions of the former State Emigration Law the expense of all these patients would have been borne out of funds created by the collection of a head tax from immigrants, and these patients would either have been cared for in the special institutions of the State Emigration Commission, or in other public institutions. Under the administration of the Federal Immigration Law, which has superseded the State Law, practically the whole of the heavy burden of expense falls upon the municipality, as the payments from the Federal "immigration fund" to the City are insignificant.

Aliens, Patients from Causes Existing Prior to Landing

As has been clearly shown in this Report, an important proportion of the patients in Bellevue Hospital were aliens who had the conditions resulting in their presence at the Hospital as public charges before they were landed in this country. Their cases were taken up for special consideration. The Federal Immigration Law, in the provisions that most directly affect the hospitals, specifies certain diseases for which aliens are to be excluded from this country, and also provides for a certain general class of causes that have been certified to by a doctor of the United States Public Health Service as "affecting ability to earn a living," for which immigrants may be debarred from landing. Consequently, these cases have been separated according to the distinctions in the Federal Law. The diagnoses of the 185 cases judged by the investigators and medical examiners of this Committee to have had the causes of their dependence prior to landing appear in Table XLII. The 185 patients represented by

these diagnoses are the same as those that appear in Table XXXVIII, as follows:

Class I.

1.	Aliens in the United States in violation of the Federal Immigration Law....	40
2.	Aliens deportable under the Federal Immigration Law.....	63
3a.	Aliens deportable under the State Charities Law from causes existing prior to landing.....	30
4a.	Aliens deportable (with consent) under the State Insanity Law from causes existing prior to landing.....	52
	Total.....	185

Of these 185 cases, 110, or 59.5 per cent., were cases for mandatory exclusion from this country by the Federal Immigration Law, and 75 patients, or 40.5 per cent., were certifiable as having conditions "affecting ability to earn a living." The 110 cases of patients whose admission to this country was forbidden by the Federal Immigration Law consisted of 10 cases of pulmonary tuberculosis; 15 cases of venereal diseases; 81 psychopathic cases; 2 cases of epilepsy; and 2 imbeciles.

The most frequent diagnosis among the patients certifiable as having conditions "affecting ability to earn a living" was chronic alcoholism, with which 26 patients were suffering. Chronic cardiac diseases were found in 14 aliens; chronic gastritis in 6; various joint affections in 5; and chronic arthritis in 1. Also, there were 3 patients with chronic otitis media; 5 pregnant women, 1 of whom had a childbirth, and another an abortion; and 1 case of exophthalmic goiter. There were also individual cases of the following diagnoses: Urethral fistula; hypospadias; salpingitis; hernia; malignant tumor; chronic emphysema; empyema; congenital malformation of toe; malaria; asthma; erysipelas; carbuncle; and acute alcoholism.

When it is borne in mind that to reach the number of cases that would be admitted to Bellevue Hospital in a year these figures must be multiplied by the number of months, and also that there must be added to them 22.5 per cent., in order to represent the proportion of cases with incomplete histories during the 31 days, it will be seen that the number of aliens who would come into the Hospital within a year as public charges from causes existing prior to landing is large. For example, there would be 1,345 aliens admitted to this one institution during a year whose entrance to this country is forbidden by the Federal statutes. Also, there would be 917 patients in the Hospital in a year certifiable to by the doctors of the United States Public Health Service as having conditions "affecting ability to earn a living." The total aliens who would be patients from causes existing prior to landing would be 2,262 for a year.

Conditions Suggested as Accounting for Patients from Prior Causes

It is one thing to show that the Immigration Law has not protected this country entirely from the burden of alien dependents, but it is quite another thing to know to what causes existing at the time of their entry into this country may be attributed the presence of immigrants in our institutions. With this object in view, the method of the medical examination of immigrants by the immigration authorities was inquired into and observa-

tion made of the conditions under which these aliens were examined. Furthermore, a search was made of the ships' manifests for two-thirds of the aliens in this country less than 6 years, to discover if there was any annotation upon the ships' manifests at Ellis Island that any of these patients had been certified by the doctors as mandatorily excludable; as having conditions "affecting their ability to earn a living"; or that any had been referred to boards of special inquiry. Of the whole number so examined in the government records, only 2 individuals were found to have come before a board of special inquiry. This search seemed so unproductive of results that, on account of the pressure of other work, it was abandoned without the records for all the cases having been examined.

Some of the conditions surrounding the examination of immigrants at landing, however, and the cases whose presence in the Hospital might reasonably be attributed to these conditions will be found in Table XLIII. There were 105 such cases among the 185 patients admitted to Bellevue Hospital in the period of 31 days as public charges from causes existing prior to landing. It would have been difficult or impossible to detect the remaining 80 cases, even with far more adequate facilities than are available for the United States Public Health Service to-day, principally on account of the probably incipient or inactive stages of their conditions.

The 105 patients whose condition causing their presence in the Hospital could probably have been detected with proper facilities, appear to have escaped detection for the following reasons: There were 40 cases whose presence as dependents, sometimes within a very few days after landing, may have occurred because of the lack of a quiet place for the examination of the hearts and lungs of the immigrants, and the lack of facilities for undressing them. There were 40 other cases that it seems fair to say may have been allowed access to the country on account of the lack of medical interpreters at the disposal of the examining officers of the United States Public Health Service, and the lack of facilities for detaining suspected psychopathic cases. The insufficient oversight by the immigration authorities of the crews of ships and the ease with which members of these crews can desert seemed responsible for the presence of 6 aliens in the Hospital. The lack of a proper place for the examination of discharged seamen would account for 5 more. Two cases of epilepsy may have been hard to detect without prior medical history; and 1 case of congenital malformation of the toe may have appeared of insignificant consequence in the examination of the immigrants. There was 1 interesting case of a patient landed at a private hospital by the permission of the United States immigration authorities, and transferred from this hospital to become a charge at the City's expense (not reimbursed to the City). Finally, there were 10 cases for whose presence in the country it seemed difficult to assign any reason but oversight on the part of the medical examiners. The diagnoses in these 10 cases were: imbecility in 2 cases; senile dementia in 1 case, at Bellevue Hospital within 2 months after landing; chronic otitis media in 2 cases; exophthalmic goiter in 1 case; paresis in 1 case, in Bellevue within 6 weeks after landing; chronic pulmonary tuberculosis in 1 case, in Bellevue when only 3½ months in the country; parturition in 1 case, after 6 weeks in the United States; and chronic emphysema in 1 case.

Among these 105 cases were 55 that were mandatorily excludable, and 48 that could have been certified to as having conditions "affecting ability to earn a living." Of the 2 other cases, 1 possibly seemed trivial on entry, and the other was the case of the woman in the private hospital

referred to. The mandatorily excludable cases consisted of 28 insane immigrants; 15 with venereal diseases in the active stage; 8 with pulmonary tuberculosis; 2 with epilepsy; and 2 imbeciles.

Alien Seamen

One very interesting fact developed during this investigation was the presence of alien seamen in the Hospital, both those who claimed to have been discharged from their ships and those who had deserted, as may be seen by referring to the Appendix of this Report for the digest of the histories, under Class I—1 Aliens in the United States in violation of the Federal Immigration Law, and also in Class I—2 Aliens deportable under the Federal Immigration Law. In Class I—1, over 25 per cent. of the patients were seamen. In most of these cases competent medical examination by the United States Immigration authorities should have detected the conditions which led to the dependence of these alien seamen. In the case of only 1 was any payment made by the steamship companies. On the basis of those found in the 31 days among the completed cases there would be 160 alien seamen admitted to this one hospital in a year who would be there in violation of the Federal Immigration Law.

There is no statute known in the Immigration Law which compels steamship authorities to present seamen to the immigration authorities before discharging them, although there was a Regulation, issued under the former Department of Commerce and Labor, based upon what was considered the intent of the law, requiring discharged seamen to be so presented. Again, it is understood that the seamen that are voluntarily presented by the steamship companies for examination are brought either to the Manhattan pier of the Ellis Island ferry, or are presented at the time of landing with the second cabin passengers. In neither case are there facilities for undressing these seamen for thorough examination.

Non-Residents of New York State

The City is interested in knowing not only what proportion of its burden comes to it from other countries, but also to what extent it is assuming the responsibility of caring for those who have not gained a legal settlement in this State. Among the 2,819 patients who were classified according to their citizenship and were tabulated in Table XXXVIII, which has already been discussed, there were 1,793 citizen residents in New York City (Class III), and 1,026 alien and non-resident patients (Summary C).

These 1,026 alien and non-resident patients were tabulated according to the length of their stay in New York State. This tabulation appears in Table XL. In this table four groups are made of these 1,026 patients, as follows:

Patients who had been in the State of New York less than 2 months (which practically approximates the period within which dependents are "State Poor"), 154; who were maintained 1,627 days in the Hospital, at an expense of $2,944.87. These 154 patients were 16.1 per cent. of the 1,026 aliens and non-residents of the City.

Patients in New York State for as long as 2 months and less than 1 year, 168; who remained in the Hospital 1,954 hospital days, up to September 9, 1913, at an expense of $3,536.74.

Patients whose length of stay in the State could not be positively

stated, 71. Almost all of these patients were suffering from some mental disability or weakness, consequently, information as to their residence in the State was lacking. They remained in the Hospital 401 days, at a total expense of $725.81.

Patients over 1 year in New York State, 633 cases. Of these, 594 were aliens who had been in New York City over a year, and 39 were non-residents of the City.

If the proportion of patients in the State of New York less than 2 months to the total 1,026 cases classified be extended to cover the 71 patients whose residence was unknown, and 22.5 per cent. be added for a proportion to represent the patients in the 31 days whose histories were not completed, the total expense to the City of maintaining patients admitted in this month who had been less than 2 months in New York State would have been $3,692.83. On this basis the maintenance of this class for a year would be $44,313.96, and the number of such patients would be 2,367.

It is recognized that there is 1 day's difference between the 60 days maximum residence for patients defined as "State Poor" and the 2 months used in the foregoing classification, but it is considered no exaggeration to say that the State Poor maintained in Bellevue Hospital would cost the City this much a year, as there is a certain proportion of patients who may have been in New York State more than 2 months, but who, nevertheless, have not resided in any county of the State for the period of 60 days, and are, therefore, State Poor by the definition of the law.

By an extension of the proportion of the total patients in New York State less than 1 year, which included those in the State less than 2 months, and also those over 2 months, to cover the 71 cases whose residence in the State was not clearly established, and the same proportion among the patients with incomplete histories as existed among those classified in Table XXXVIII, it is estimated that the total expense to the City of maintaining patients who were non-residents of the State admitted to Bellevue Hospital during these 31 days, from the date of the admission of each to September 9, 1913, amounted to $8,148.91. On this basis the expense for a year would be $97,786.92, exclusive of the expense connected with grounds, buildings, and equipment, and there would be 5,086 admissions of such patients.

It is also interesting to notice in this table (Table XL) that about one-half of the patients in the State less than 2 months, or 77 cases, were deportable aliens, whose expense approximated one-half the total expense of all patients falling in this class. Also, it is important to observe that a substantial majority of the patients in the State less than 1 year were aliens, and that about 40 per cent. of the patients in the State less than a year were deportable aliens.

Non-Residents of New York City

While the City of New York is indirectly affected by the burdens of the State, nevertheless the problem with which the municipal authorities have to deal is a local one. Consequently, it is of prime importance for the City to know what dependents that it is maintaining have gained a legal settlement in the City by residing here 1 year as required by law. Accordingly, the 1,026 alien and non-resident patients found to have been admitted to Bellevue Hospital in the period of 31 days covered by the

examination were tabulated according to their length of stay in New York City (Table XLI). There were, as may be seen in this table, 361 patients admitted in this period who had lived less than 1 year in New York City, who had remained in the Hospital 4,017 days, up to September 9, at an expense of $7,270.77.

There were, however, 71 cases whose length of stay in New York City could not be positively given. If the proportion of patients in the City less than 1 year to the 955 cases classified for State residence be extended to cover these 71 cases, and 22.5 per cent. added to include the proper proportion of the incomplete histories, the number of patients with less than 1 year's residence in the City admitted for a year would be 5,568, and their expense $112,074.12. Of these cases, 3,156 would be aliens, maintained at an expense of $61,041.84, and 2,412 citizen non-residents of the City, at an expense of $51,032.28. For these patients admitted during the period of 31 days there was received only the sum of $187 prior to September 1, 1913.

Of these 361 cases in the City less than 1 year, 36 aliens and non-residents, or 10 per cent., had been in the City less than 1 day; 68, or 18.8 per cent., had been in the City less than 3 days; 86, or 23.8 per cent., less than 1 week; 137, or 37.9 per cent., less than 1 month; 168, or 46.5 per cent., less than 2 months; and 268, or 74.2 per cent., less than 6 months. Of the 955 alien and non-resident patients that could be classified according to their length of stay in the City, 37.9 per cent. had been in the City less than 1 year; 28.2 per cent. less than 6 months; 17.7 per cent. less than 2 months; 14.4 per cent. less than 1 month; 9.1 per cent. less than a week; 7.2 per cent. less than 3 days; and 3.8 per cent. less than 1 day.

Of the 361 non-residents of the City admitted in 31 days, 197 were aliens (including 128 deportable aliens), as compared with 164 non-resident citizens. According to this showing, in a year there would be 3,156 alien non-residents of the City maintained at public expense in this institution, out of which 2,244 would be deportable from the United States. The estimated expense of the alien non-residents admitted during the 31 days was $5,086.82, of which amount $3,075.63 was incurred for the maintenance of deportable aliens. For the period of a year this expense would be, in proportion, $61,041.84 for the hospital care of alien non-residents of the City, exclusive of the cost of grounds, buildings, and equipment, including $32,644.56 for the maintenance of aliens who could be deported under the Federal or State laws.

ALIENS, NON-RESIDENTS, AND STATE POOR IN THE DEPARTMENT OF PUBLIC CHARITIES

The situation in the Department of Public Charities is considerably clearer than in the Department of Bellevue and Allied Hospitals; for under the Charter of New York City, as already quoted in this Report, the specific statement is made that the Commissioner of Public Charities is the Overseer of the Poor of New York City, while such statement is lacking in the case of the Board of Trustees of Bellevue and Allied Hospitals.

The Commissioner of Public Charities as Overseer of the Poor is intrusted with the care of all public charges as poor persons in all institutions within the City, outside of the Departments of Health and Bellevue and Allied Hospitals. This Commissioner is, furthermore, empowered and required to investigate the propriety of the relief of applicants by the City. Also, as Overseer of the Poor he is authorized to cause all State Poor persons to be conveyed, upon warrant issued by him, to the State Almshouses, there to be maintained for a stipulated weekly rate, to be paid by the State Board of Charities. Furthermore, as Overseer of the Poor he is empowered to make demands upon the superintendents or overseers of the poor in other towns and counties for the maintenance of public charges in New York City who have had a settlement in those localities and are properly chargeable to them.

From the records of the Department of Public Charities it appears that there have been many thousands of aliens dependent in its institutions, and as public charges in the private institutions. No examination in this connection was made of any institutions in this Department other than the examination of the almshouses hereafter covered in this Report and in the report of this Committee on "Admissions to City Homes," but the following general data was thought to be important.

A great disparity existed between the number of cases that could have been deported from Metropolitan Hospital in the year 1911 and those that actually were deported, according to the table of deportation cases compiled from the Annual Report of the Department of Public Charities for that year, to be found as Table LIV. According to the figures from the Hospital there were 1,584 deportation cases of patients in the institution in this year, of which number only 269 were deported, while 1,073 cases left the institution by the ordinary method of discharge. If we exclude from the total number of deportation cases in this institution during this year the 92 patients who died, there were deported only 18 per cent. of the deportable patients. The number of deportation cases discharged was four times as large as the number removed.

The Brooklyn Bureau of Dependent Adults, according to its section of the Annual Reports of the Department of Public Charities for the years from 1906 to 1911, notified the State Board of Charities of the dependence of 961 public charges of whom this Bureau desired the City to be relieved. However, according to this Bureau, only 41 per cent. of

the cases reported in these years were taken away by the State Board. (Table LV.)

The first record of any payments made by the Federal Government to the Department of Public Charities occurs in the Annual Report of the Department for the year 1910, where there is a statement of the receipt of $5,662.83 for the maintenance of aliens. In the year 1911 a similar record is made of the receipt of $9,286.57. These payments were made to the Department by checks from the State Board of Charities. The Government has refused to make any payment for deportable aliens who have been held in an institution of the Department of Public Charities and have died there.

During the year between July 1, 1911, and June 30, 1912, the Brooklyn Bureau of Dependent Adults referred 105 cases of supposed non-resident and alien poor to the State Board of Charities. The monthly reports of this Board show only 20 of these cases to have been removed from the institutions of that borough.

The 85 cases that were not removed from these institutions, according to the records kept in the Bureau, consisted of 25 non-residents and 60 aliens. Among the 105 cases reported were 5 entered upon the records of the Bureau as State Poor. This Bureau has no knowledge of payments that are made for aliens and State Poor maintained within this district, as all such payments are received in the Commissioner's office in Manhattan. A considerable proportion of these Brooklyn cases were looked up in the records of payments made by the State Board of Charities, both for aliens and for State Poor, but no evidence could be found that any payments had been received for any of them.

The Bureau of Dependent Adults in Richmond had applications, principally for hospital care, of quite a number of alien dependents. Some of these were reported by the Bureau to the State Board of Charities, but the Bureau had no knowledge as to what action was taken.

The State Board of Charities not only removes aliens from public institutions, but also removes from private institutions dependents referred to the City for acceptance as public charges. In the file of cases at the Manhattan Bureau of Dependent Adults there were 843 names of alleged aliens and non-residents that had been reported to the State Board of Charities in the first 6 months of 1912 for investigation and possible removal from public and private institutions in the City. During the same period the State Board of Charities and the United States Immigration Service removed from these institutions only 504 dependents, less than two-thirds as many as had been reported.

The work of the Department of State and Alien Poor of the State Board of Charities in New York City for the fiscal year ending September 30, 1912, will be found in Table XLIV. This table was compiled from the monthly reports of this Department of its removals of aliens and non-residents from the City, and also of the removals of aliens by the United States Immigration Service that had been reported by the State Board. There were 1,353 removals made from Greater New York in this year, of which number the State Board made 1,309 and the United States officials only 44. As the removals by the latter body were of aliens only, and as the State Board removed 688 individuals to other countries, according to its reports, it would appear that the United States Immigration Service made only 6 per cent. of the removals of aliens, while the State Board made 94 per cent.

If the Superintendent of State and Alien Poor has continued the practice reported by him for 1911 (page 124 of this Report) of customarily reporting all aliens found by the State Board in public institutions to the United States Commissioner of Immigration, it would appear that this has been a comparatively fruitless task.

Of the 1,353 removals, 877 were from the Department of Public Charities, of which, 811, or 92 per cent. of the total from this Department, were from four Manhattan institutions. In addition to these there were 183 cases removed from various private institutions. The majority of these cases presumably had been referred to the Department of Public Charities by the private institutions as charges for whose maintenance and care the City should pay.

Of the 877 removals from the Department of Charities 464, or over 50 per cent., were sent to other countries, while 128, or nearly 60 per cent. of those removed from private institutions, and all of those from the Department of Health, and from the State institutions, were for deportation.

Aliens, Non-Residents, and State Poor in Municipal Almshouses

Aliens

An examination was made of the New York City Home for the Aged and Infirm located on Blackwell's Island to ascertain what inmates within the institution were aliens, non-residents, and State Poor. The Home is a State Almshouse for the reception of State Poor by virtue of a contract between the State and the City authorities in accordance with the law.

This examination took place on December 9, 1912, and all names of dependents appearing upon the registers as inmates of the institution were taken into account. Of these, 1,656 were entered upon the records as citizens, while 442 were entered as aliens. In the case of the remainder of the dependents the records did not show whether they were citizens or aliens. The 442 alien dependents, which were 21.5 per cent. of all inmates that could be classified, were supported in this institution at an expense of $128.71 per day for their local maintenance only, exclusive of all general, administrative, transportation, and other charges of a general or permanent nature.

Accepting the proportion of aliens to citizens as an average proportion, and estimating the daily average census of dependents in this institution for the year 1912 to have been 2,583, the estimated daily average of aliens in this institution in this year would have been 555. The estimated expense for maintenance of these aliens in this institution for this one year would have been $64,300, exclusive of all overhead or corporate stock expenses. The overhead charges in the Department, if reckoned against the institutions, would raise their per capita expense about 30 per cent. The cost of the maintenance of these aliens, then, approximated $83,500, excluding charges for permanent investments.

On the basis of the proportion of aliens to citizens found in this Home there would have been an average of 281 aliens daily in the Brooklyn City Home, maintained at an annual expense for the year 1912 of $33,400, excluding the charges of a permanent character. Also, there would have been an average daily number of 215 at Farm Colony, costing the City for the year 1912 $34,800 for local current expense only, or $45,200 exclusive of corporate stock expense. The total estimated average number of aliens in the City's almshouses for this year would have been 1,051, maintained by the City at an expense of $132,500, exclusive of all overhead or carrying charges; or $172,000 inclusive of overhead charges but exclusive of the carrying charges.

It would be necessary to remove all aliens from the almshouses in order to save yearly the above indicated amount of $172,000. Though the State Board of Charities has the power to make such removals, in some cases it might not be considered advisable to remove; especially where a dependent had lived for many years in this City, though not having become a citizen of the United States. The State may deport an alien regardless of the length of time that he may have resided in the State. If we assume that it is reasonable to deport an alien having become dependent within a period of 5 years from the time of his arrival, or a dependent that has been in

the country over 5 years but whose near relatives are not in this country, under such practice, a large proportion of the above indicated number of aliens—1,051—would be deported. Even with a liberal interpretation of the time within which it would be just to deport an alien, the City would save many thousands of dollars annually if the State Board of Charities should exercise its power of removal within reasonable time limitations.

Recent admissions to the almshouse on Blackwell's Island have shown a higher percentage of aliens among them than was found among the inmates in the institution on December 9, 1912. In the Report of this Committee on "Admissions to City Homes" are given the proportions of aliens among the male admissions to this Home that could be classified, in December, 1911, and in May, 1912. From the investigation made in this study it was ascertained that 43.6 per cent. of the admissions that could be classified in December, 1911, and 30.2 per cent. of the admissions in May, 1912, or a mean of 34.8 per cent. for the 2 months were of aliens.

In the Annual Reports of the Department of Public Charities from 1908 to 1911, inclusive, statements were made that the Bureau of Dependent Adults in Manhattan committed yearly from 1,200 to 1,500 aliens to this Home, exclusive of the State Poor committed to the same institution. (Table XLV.)

Non-Residents

The examination made of the Manhattan City Home did not disclose more than 23 dependents entered upon the register as non-residents of New York State remaining in the Home on December 9, 1912. No information was available as to how many of the inmates were non-residents of this City. Six per cent. of the male admissions in December, 1911, and May, 1912, were definitely ascertained to have been non-residents of the City. It seems inadvisable to attempt to estimate the number of non-residents in almshouses on such meagre data.

State Poor

On June 20, 1875, the State Board of Charities made a contract with the authorities at that time in charge of the poor relief in the County of Kings. The State Board, in accordance with Article 7, Sec. 90, of the Poor Law, designated the Kings County Almshouse, now known as the New York City Home for the Aged and Infirm, Brooklyn Division, as a State Almshouse, and agreed to pay the authorities in charge of this Almshouse for the State Poor persons committed to and maintained by them at the rate of $2.50 a week. A similar contract was entered into with the Department of Public Charities on Feb. 28, 1902, when the New York County Almshouse, on Blackwell's Island, now known as the New York City Home for the Aged and Infirm, Manhattan Division, was also designated as a State Almshouse, and the State agreed to pay $2.50 a week for the maintenance of State Poor at this institution also. After the contract was entered into by which the latter Home became a State Almshouse, the number of State Poor committed and the number supported annually in the Brooklyn City Home was reduced to about 10 per cent., and less, of the number committed and maintained in 1902 in this institution. For example, there were committed in 1902, 681 State Poor, and the whole number supported in that year was 710, whereas in the year 1903 there were only 66 committed and 72 maintained in the same Home. This decrease was more marked in subsequent years. As will be seen in Table

XLVI, the number committed in 1904 was only 40; in 1905, 48; in 1906, 47. There was a slight increase in 1907 to 56 State Poor committed to this Home. This was followed in 1908 by a marked reduction to only 20 cases. The figures for the 1909 commitments to this Home do not appear in the Annual Report of the State Board of Charities for that year, but in 1910 there were only 44 committed, and in 1911 only 20. Similarly, the total number of those supported diminished, as will be seen from the same table. The first 2 years of this 10-year period were marked by the commitment of a large number of State Poor to the Manhattan City Home. There were 634 committed in 1902 and 933 in 1903. In 1904, however, the number committed dropped to 532, and the following year to 126; after that it did not exceed 234 in any one year of this 10-year period.

The marked decrease in the number of State Poor reported and maintained by the State in the State at large has been commented upon in the opening section of this Report dealing with the State Poor, and an explanation will be found there in which the State Board attributes this falling off to their more rigid examinations of alleged State Poor and speedier removals.

It is remarkable that, while from 1902 to 1911 the burden of the City had increased steadily, the payments by the State for the maintenance of State Poor in two of the City's almshouses decreased. In the year 1902, according to the records of the Department of Public Charities, that Department received $5,516.44 for the maintenance of State Poor in New York City, whereas the sum paid for this maintenance in 1912 was only $606.79 Nor was this diminution in the payment from the State to the City for such charges made up for by any corresponding increase in the expense incurred by the State in removing these State Poor cases from New York State. On the contrary, it was found that, whereas in 1902 there was $9,062.54 spent in such removals, this expenditure had decreased to $1,595.36 in 1909, and to $2,816.36 in 1911. Again, the proportion New York City received out of the entire funds paid to New York State decreased from 43 per cent. in 1902 to as low as 10 per cent. in 1906, and although there were variations in the percentage received by the City during the next 4 years, at no time did it exceed the 18 per cent. paid to the City in 1910. In 1911, the last year for which information was available, only 14 per cent. of the total expense of maintenance paid by the State was paid to New York City. In figuring these percentages attention is called to the fact that the year represented in the Annual Report of the Department of Public Charities does not correspond exactly to the year of the Reports of the State Board of Charities, the fiscal year in the latter ending September 30, and of the former December 31. This, however, does not affect the fact that there has been a very marked decline in the proportion of the maintenance of State Poor paid to New York City. (Table XLVII.)

The removals of the State Poor by the State Board of Charities from New York City formerly constituted a large majority of the removals from the entire State, including the City. For example, in the year 1902, and also in 1903, 82 per cent. of the removals of State Poor from the entire State were from the two City Homes of New York City. In the year 1911 this proportion was just one-half, or 41 per cent. (Table XLVIII.)

The decision as to who should be considered a State Poor person and who should not would seem to be made by the State Board of Charities

alone. The basis of their decision would seem to have been set forth in the report of the Committee on State and Alien Poor for the year ending September 30, 1904, in Vol. I of the Report of the State Board of Charities for that year, as follows:

> The test of more than sixty days' residence in a county has not been qualified in the law by any condition. It rests upon the presence of the person within the county limits for more or less than sixty days. It does not matter what the person has been doing during the period, or what his condition has been if he has not within the time made application for relief to a public officer authorized to dispense the same. The liability of the State, county or town is settled by the actual presence of the person within a county for the prescribed period of time.
>
> The law now depends upon no individual's judgment. It specifically sets forth the qualifications of a State poor person, and for this reason all persons who come under its provisions must receive the same consideration, irrespective of the temperaments of administrative officers. All counties are treated alike, for to all cases the one standard is applied.

In spite of the clear-cut definition given in these extracts from this report there has been wide variance apparent between the opinion of the Bureau of Dependent Adults, Manhattan, of the Department of Public Charities, and the opinion of the Department of State and Alien Poor of the State Board of Charities as to who have been State Poor. For example, it is shown in Table XLIX that, according to the State Board of Charities, in the period of 10 years from 1902 to 1911 there were (omitting the year 1909, for which the State Board did not publish the figures on this point) 3,161 State Poor committed to the Manhattan City Home, whereas for the same years, according to the reports of the Bureau of Dependent Adults, Manhattan, there were 6,185 State Poor committed to this same institution. From these figures it would seem that only a little over one-half of those that the Bureau of Dependent Adults classed as State Poor among the commitments to this one institution were so recognized by the State Board of Charities.

There is kept at the Manhattan City Home, which is a State Almshouse, what is called a "State Register" in which the names of those public charges that are classed as State Poor are entered. During the year ending September 30, 1912, there were 181 such persons entered upon this book. The disposition of these alleged State Poor as entered upon this same Register is given in Table L. There were 51 out of this total of 181, or 28 per cent., discharged as not proper State cases. As a result of the large discrepancy between the reports of the Bureau of Dependent Adults and of the State Board of Charities as to the number of State Poor maintained in this institution, there was also a great discrepancy in the return made to the City for the number of State Poor accepted as State charges and maintained in this institution, and the amount it is estimated might have been due the City if the State had accepted all cases classed as State Poor by the Bureau. In Table LI there is an estimate of the expense of the State Poor maintained, based on the number reported to have been in the institution by the Bureau of Dependent Adults. The average per capita per diem expense for these dependents to the City was ascertained from the Annual Reports of the Department of Public Charities. The average days stay for the dependents termed State Poor by the Department of Charities is not known. The average of the stay of the inmates in this almshouse on a certain day was found to be 1,004 days, but this number was not accepted as the average stay in making this

estimate. Instead, the very low average stay found in the State Board of Charities' Annual Reports from the number maintained, and the amount paid during the year for this number, with the known rate of $2.50 per week, was accepted. This number varied in these 10 years from a minimum of 8 days in 1911 to a maximum of 18 days in 1905. The average number of days in each year will be found in this table. This estimate shows that there was a net loss to the City in 9 of these 10 years of $12,435.37. The year 1909 was not included in this estimate, as the State Board did not publish the necessary data in its Annual Report for that year. The total payments made by the State Board of Charities to the Department of Public Charities for the maintenance of the State Poor in this institution for these years was $15,692.10. It will be seen from this table that the ratio of the estimated amount due to the City for the State Poor maintained according to the Department of Public Charities to the amount paid to the City for the State Poor maintained, according to the judgment of the State Board of Charities, was 73 to 100.

The State Poor entered upon the "State Register" at this institution for the year ended September 30, 1912, for whom bills were said to have been rendered to the State Board of Charities numbered 126. As shown in Table LII, according to the entries in this book, only 35 of these 126 cases, or 28 per cent., had been inmates of the City Home; 11 had been in the Municipal Lodging House; 37 in City Hospital; 28 in Metropolitan Hospital; 2 were in Bellevue Hospital; and 1 in each of two private institutions, the Misericordia Hospital and the Society for the Prevention of Cruelty to Children.

In view of the very large decrease in the number of State Poor maintained by the State Board of Charities at this institution it is interesting to notice the following cases that were admitted to this institution in the month of December, 1911. During this period there came to this Home 9 cases (among the males only) that fell within the class of State Poor, according to the law placing all dependents with less than 60 days residence in the State in this category. Digests of these cases follow:

Case 1. A native of Ireland, 35 years of age. Eleven days in the United States and the same time in the City. This dependent was reported to the State Board of Charities by the Bureau of Dependent Adults and was removed from the almshouse by the State Board on the 12th day of his stay there. He was taken to City Hospital the following day, and removed from the latter institution on the 25th day of his stay there, or on the 37th day of his stay in the two institutions, and returned to Ireland by the State Board of Charities. This dependent does not appear on the State Register as a State Poor case.

Case 2. A native of the United States, 54 years of age. Four days in New York State according to the City Home record. This case was reported to the State Board of Charities by the Bureau of Dependent Adults upon the date of his admission, and was removed by the State Board the 9th day of his stay in the Home and sent to Connecticut. Although this case came within the cognizance of the State Board of Charities it was not entered upon the State Register as a State Poor case.

Case 3. A native of the United States, 28 years of age. Two days in New York State according to the City Home record. This case was reported to the State Board of Charities by the Bureau of Dependent Adults upon the date of admission, and was removed from the almshouse by the State Agent on the 11th day of his stay there and sent to Kentucky. Although this case came under the

cognizance of the State Board of Charities, it was not entered upon the State Register as a State Poor case.

Case 4. A native of England, 24 years of age. Three weeks in New York State according to the City Home record. This case was reported to the State Board of Charities by the Bureau of Dependent Adults, and was removed from the almshouse by the State Board on the 6th day of his stay there and sent to Chicago. This dependent had previously been an applicant for relief from a private society. Although his case came within the cognizance of the State Board of Charities, it was not entered upon the State Register as a State Poor case.

Case 5. A native of Ireland, 21 years of age. Six weeks in the United States and New York City according to the City Home record. This case was reported to the State Board of Charities by the Bureau of Dependent Adults on the date of admission to the almshouse, and was removed therefrom on the 40th day of his stay by an agent of the Federal Government and returned to Ireland. Although this case came within the cognizance of the State Board of Charities, it was not entered upon the State Register as a State Poor case.

Case 6. A native of Germany, 65 years of age. Six weeks in the United States and in New York City according to the record in the City Home. This dependent, according to the Home records, "eloped" from this institution on the 63rd day of his stay there, but according to the reports of the State Board of Charities he was removed from this Almshouse on the 72nd day of his stay there and sent to Canada. Although this case came within the cognizance of the State Board of Charities it was not entered upon the State Register as a State Poor case.

Case 7. A native of the United States, 67 years of age. Five days in New York State according to the records of the City Home. This dependent was transferred from this Home to Farm Colony on the 63rd day of his stay at the Home. He absconded from the latter place after 22 days, or on the 85th day of his stay in the two institutions. This case was not entered upon the State Register as a State Poor case.

Case 8. A native of Ireland, 68 years of age. Four days in New York State according to the record at the City Home. This dependent was admitted to this Home by transfer from Bellevue Hospital after a stay of 4 days. He was discharged from the Home upon the 79th day of his stay there. His name was not entered upon the State Register as a State Poor case.

Case 9. A native of the United States, 45 years of age. Four weeks in New York State according to the records of the City Home. This case was entered upon the State Register after admission. He was removed from the Home on the 9th day of his stay there by the State Board of Charities and sent to Illinois.

Removals

Among the dependents in the Manhattan City Home at the time of the examination, December 9, 1912, there were found 290 aliens and non-residents that had been admitted in the years 1911 and 1912 and were still remaining there.

During the first half of the year 1912 there were 1,944 admissions to the Home. If the proportion of aliens among these is the same as the proportion found in the Home December 9, 1912, namely, 21.5 per cent., there must have been 418 aliens admitted to the Home during this period. The Annual Reports of the Department of Public Charities seem to indicate that this number is an under-estimate, as they show that between 1,200 and 1,500 aliens have been admitted to the Home annually (Table XLV). The monthly reports of the State Board of Charities of removals from institutions in Greater New York show only 80 dependents to have been removed from this institution during this time.

An examination was made of the file at the Manhattan Bureau of Dependent Adults of the alleged aliens, non-residents, and State Poor that were reported by this Bureau to the State Board of Charities for investigation for removal after their commitment to the Manhattan City Home. There were 133 such cases found in this file. Investigation of the records at the Home showed that these cases were disposed of as listed in Table LIII. According to this table 19 of these cases were removed for deportation to other countries either by an agent of the State Board or of the United States Immigration Service, and 24 were removed to be sent to other states. The records showed that 39 were discharged to the State Agent, but the final disposition of these is not given. Of these 133 cases, 15 were discharged from this institution upon the recommendation of the Department of State and Alien Poor of the State Board to that effect, which implies that this Department had decided that these dependents should not be removed at State expense; and 11 were discharged without any reason being entered. Of these 133 dependents, 1 died in the institution and 19 of them could not be found entered upon the register at the Home. There was 1 dependent who, according to the records of the institution, had been returned to the ship. This dependent was an alien who had been only 8 days in the United States prior to his admission at this time to the City Home. This alien was discharged about 3 weeks after his admission to the Home, and but 12 days after this discharge he was committed to City Hospital through the Manhattan Bureau of Dependent Adults, and, according to the records, the Bureau again called the attention of the State Board of Charities to the dependence of this alien upon the City. This dependent, however, left the Hospital 4 days after admission, not to go to a foreign country, but, according to the records, his address was in New Jersey.

Among the 4 dependents remaining in the institution in 1913 there was 1 that had been admitted in July, 1912. The State Board of Charities had recommended that this dependent be discharged, but on account of lameness he was allowed to remain in the Home. Another of these 4 had been in the Home for 3 weeks prior to the investigation by the Committee on January 8, 1913. Each of the 2 others had been in the Home for more than 3 months.

Although 65 per cent. of the admissions to the Brooklyn City Home were of foreign born dependents, as compared with the 70 per cent. of those to the Manhattan City Home, according to their reports for 1911 very few removals have been made from the former Home. In the year ended September 30, 1912, the State Board of Charities reported only 8 removals from the Brooklyn Home by its agent and no removals by the United States Immigration Service. (Table XLIV.)

The third almshouse, Farm Colony, on Staten Island, although its 1911 proportion of foreign born among its admissions was 63 per cent., had no removals whatever reported by the State Board during the same year.

TABLE I.

ADMISSIONS OF FOREIGN BORN TO NEW YORK CITY MUNICIPAL INSTITUTIONS IN 1911.

Name of Institution	Born in United States	Born in Other Countries	Total	Percentage Born in Other Countries
DEPARTMENT OF PUBLIC CHARITIES				
N. Y. City Home for the Aged and Infirm, Manhattan	1,221	2,913	4,134	70.0
N. Y. City Home for the Aged and Infirm, Brooklyn	1,216	2,244	3,460	65.0
N. Y. City Farm Colony	547	937	1,484	63.0
Almshouse Total	2,984	6,094	9,078	67.0
N. Y. City Children's Hospitals	Nativity not published			
Municipal Lodging House	95,395	72,020	167,415	43.0
Metropolitan Hospital	4,331	5,364	9,695	55.0
City Hospital	3,045	4,325	7,370	59.0
Kings County Hospital	7,734	5,357	13,091	40.0
Cumberland Street Hospital	2,070	706	2,776	25.0
Bradford Street Hospital	60	28	88	32.0
Reception Hospital, Coney Island	990	521	1,511	34.0
Hospital Total	18,230	16,301	34,531	47.0
BELLEVUE AND ALLIED HOSPITALS				
Bellevue Hospital	17,634	18,838	36,472	52.0
Gouverneur Hospital	1,660	2,733	4,393	62.0
Harlem Hospital	3,450	2,359	5,809	40.0
Fordham Hospital	2,499	1,807	4,306	42.0
	25,243	25,737	50,980	50.0
HOSPITALS IN BOTH DEPARTMENTS				
Department of Public Charities	18,230	16,301	34,531	47.0
Bellevue and Allied Hospitals	25,243	25,737	50,980	50.0
Total for Hospitals in both Departments	43,473	42,038	85,511	49.0

TABLE II.

COMPARISON OF REMOVALS OF ALIENS FROM THE ENTIRE STATE BY THE STATE BOARD OF CHARITIES AND THE RETURN OF ALIENS FROM NEW YORK CITY BY THE DEPARTMENT OF PUBLIC CHARITIES.

Year	Removed by State Board of Charities from Entire State (Including N. Y. City).	Transferred from N. Y. City Only, by Department of Public Charities to Commissioners of Immigration
1902	81	1,137
1903	93	861
1904	47	328
1905	143	43
1906	276	*
1907	413	.....
1908	761	.....
1909	577	.....
1910	738	.....
1911	1,074	.....
	4,203	2,369
Yearly Average	420 (10 years)	592 (4 years)

* Transfers by the Department of Charities direct to the Commissioners of Immigration were discontinued after the year 1905.

TABLE III.

TOTAL NUMBER STATE POOR COMMITTED TO STATE ALMSHOUSES ACCORDING TO REPORTS OF THE STATE BOARD OF CHARITIES.

Year	Number of State Poor Committed	Year	Number of State Poor Committed
1874	563	1893	1,406
1875	654	1894	1,974
1876	633	1895	2,171
1877	872	1896	2,102
1878	1,120	1897	1,987
1879	1,587	1898	1,804
1880	1,343	1899	2,049
1881	1,373	1900	1,872
1882	1,392	1901	1,685
1883	1,426	1902	1,727
1884	1,892	1903	1,436
1885	1,848	1904	971
1886	1,606	1905	543
1887	1,617	1906	521
1888	1,665	1907	632
1889	1,757	1908	651
1890	1,440	1909	569
1891	1,365	1910	514
1892	1,367	1911	592

TABLE IV.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Class I. Aliens Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

	In United States Less Than *													Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	3 Years	5 Years	In U. S. 5 Years or Unknown Time	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	2	6	..	2	4	3	4	..	..	...	21	271	$490.51	7	$166.50
2. Apparently deportable by the United States	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
3. Apparently removable by State Board of Charities	..	..	..	..	..	1	7	8	3	21	40	740	1,339.40	1	79.50
4. Apparently removable by State Board of Alienists	..	1	1	7	8	30	31	13	7	53	151	973	1,761.13	..	.....
5a. Apparently county or town cases with N. Y. City address	..	..	..	..	..	..	..	3	3	6	12	103	186.43	..	.....
5b. Apparently county or town cases without N. Y. City address	..	..	..	..	..	..	..	3	10	...	13	64	115.84	..	.....
5c. Apparently county or town cases giving no address	..	..	..	..	..	..	..	..	1	5	6	160	289.60	..	.....
6. State Poor (not in other classes)	..	..	2	10	7	3	1	5	2	38	68	445	805.45	..	.....
7. Apparently charges of steamship company	2	..	..	..	..	..	..	..	..	...	2	25	45.25	..	.....
8. Without settlement in the United States	..	..	..	..	..	22	33	..	..	...	55	338	611.78	..	.....
9. Without settlement in N. Y. State	..	..	..	..	..	..	..	1	1	4	6	44	79.64	..	.....
10. State settlement unknown	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
11. Claiming N. Y. City settlement without N. Y. City address	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
13. Apparently justifiable as City charges	..	..	..	6	..	10	5	4	2	19	46	526	952.06	14	192.50
Total	4	7	3	25	19	69	81	37	29	146	420	3,689	$6,677.09	22	$438.50

* The figures in each column under this heading exclude the figures in the preceding columns.

TABLE V.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Class II. Aliens Whose Admissions Were Not Authorized by Section 692, Subd. 7, of the City Charter.

	In United States Less Than *													Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	3 Years	5 Years	In U.S. 5 Years or Unknown Time	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	1	1	7	15	10	57	50	2	..	...	143	2,157	$3,904.17	1	$21.00
2. Apparently deportable by the United States	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
3. Apparently removable by State Board of Charities	..	..	1	7	6	23	56	36	22	71	222	2,752	4,981.12	..	.....
4. Apparently removable by State Board of Alienists	..	..	..	..	..	2	4	..	..	1	7	151	273.31	..	.....
5a. Apparently county or town cases with N. Y. City address	..	..	..	..	..	..	..	9	3	4	16	186	336.66	..	.....
5b. Apparently county or town cases without N. Y. City address	..	..	..	..	..	..	..	..	7	8	15	466	843.46	..	.....
5c. Apparently county or town cases giving no address	..	..	..	..	..	..	..	1	1	12	14	123	222.63	..	.....
6. State Poor (not in other classes)	..	3	7	26	31	2	1	4	10	21	105	1,349	2,441.69	..	.....
7. Apparently charges of steamship company	..	4	4	2	1	1	..	..	..	8	20	150	271.50	2	19.50
8. Without settlement in the United States	..	..	..	..	..	112	166	..	..	...	278	3,256	5,893.36	..	.....
9. Without settlement in N. Y. State	..	..	..	..	..	..	..	8	7	18	33	417	754.77	..	.....
10. State settlement unknown	..	..	..	..	..	..	..	3	10	49	62	872	1,578.32	..	.....
11. Claiming N. Y. City settlement without N. Y. City address	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	..	..	..	..	..	..	..	..	..	8	8	49	88.69	..	.....
13. Apparently justifiable as City charges	..	3	..	..	..	..	1	..	..	1	5	28	50.68	2	27.00
Total	1	11	19	50	48	197	278	63	60	201	928	11,956	$21,640.36	5	$67.50

* The figures in each column under this heading exclude the figures in the preceding columns.

TABLE VI.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class III. Aliens for Whose Admissions the Authorization by Section 692, Subd. 7, of the City Charter Was Not Evident.

	In United States Less Than *													Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	3 Years	5 Years	In U. S. 5 Years or Unknown Time	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	..	1	..	2	2	6	2	1	..	...	14	341	$617.21	..	.....
2. Apparently deportable by the United States	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
3. Apparently removable by State Board of Charities	..	..	..	..	1	..	2	1	1	6	11	97	175.57	..	.....
4. Apparently removable by State Board of Alienists	..	..	..	..	..	..	..	..	..	2	2	24	43.44	..	.....
5a. Apparently county or town cases with N. Y. City address	..	..	..	..	..	..	..	1	..	...	1	7	12.67	..	.....
5b. Apparently county or town cases without N. Y. City address	..	..	..	..	..	..	..	..	..	1	1	2	3.62	..	.....
5c. Apparently county or town cases giving no address	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
6. State Poor (not in other classes)	..	..	2	2	2	..	..	2	1	2	11	18	32.58	..	.....
7. Apparently charges of steamship company	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
8. Without settlement in the United States	..	..	..	..	..	13	11	..	..	...	24	163	295.03	..	.....
9. Without settlement in N. Y. State	..	..	..	..	..	..	1	1	1	...	3	20	36.20	..	.....
10. State settlement unknown	..	..	..	..	..	..	..	1	2	8	11	78	141.18	..	.....
11. Claiming N. Y. City settlement without N. Y. City address	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
13. Apparently justifiable as City charges	..	..	..	..	..	..	..	..	..	...	...	....	.....	..	.....
Total	..	1	2	4	5	19	16	7	5	19	78	750	$1,357.50	..	.....

* The figures in each column under this heading exclude the figures in the preceding columns.

TABLE VII.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class IV. Citizens Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

	In New York City Less Than *										Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
3. Apparently removable by State Board of Charities	9	17	2	8	3	10	6	55	582	$1,053.42	....	.....
4. Apparently removable by State Board of Alienists	12	7	3	5	3	2	4	36	197	356.57	....	.....
5a. Apparently county or town cases with N. Y. City address	3	1	6	7	3	18	12	50	541	979.21	....	.....
5b. Apparently county or town cases without N. Y. City address	11	14	2	3	1	1	5	37	377	682.37	....	.....
5c. Apparently county or town cases giving no address	....	....	....	....	....	....	....	....	....	.....	....	.....
6. State Poor (not in other classes)	20	18	6	13	2	....	....	59	379	685.99	....	.....
7. Apparently charges of steamship company	....	....	....	....	....	....	....	....	....	.....	....	.....
8. Without settlement in the United States.	....	....	....	....	....	....	....	....	....	.....	....	.....
9. Without settlement in N. Y. State	....	....	....	....	....	....	....	....	....	.....	....	.....
10. State settlement unknown	....	....	....	....	....	....	....	....	....	.....	....	.....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....	....	....	....	.....	....	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	1	3	....	....	....	....	7	11	69	124.89	....	.....
13. Apparently justifiable as City charges	20	19	4	15	6	4	8	76	628	1,136.68	46	$466.00
Total	76	79	23	51	18	35	42	324	2,773	$5,019.13	46	$466.00

* The figures in each column under this heading exclude the figures in the preceding columns.

TABLE VIII.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class V. Citizens Whose Admissions Were Not Authorized by Section 692, Subd. 7, of the City Charter.

	In New York City Less Than *										Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
3. Apparently removable by State Board of Charities	12	16	12	35	21	41	37	174	1,758	$3,181.98	....	.....
4. Apparently removable by State Board of Alienists	1	1	....	1	....	1	1	5	81	146.61	....	.....
5a. Apparently county or town cases with N. Y. City address	....	....	2	11	8	21	11	53	583	1,055.23	....	.....
5b. Apparently county or town cases without N. Y. City address	10	22	4	10	....	3	4	53	726	1,314.06	....	.....
5c. Apparently county or town cases giving no address	....	3	1	2	1	2	....	9	43	77.83	....	.....
6. State Poor (not in other classes)	6	14	9	31	15	....	....	75	539	975.59	....	.....
7. Apparently charges of steamship company	....	....	....	....	....	....	....	....	....	.....	....	.....
8. Without settlement in the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
9. Without settlement in N. Y. State	....	1	2	....	....	33	29	65	758	1,371.98	....	.....
10. State settlement unknown	2	10	4	17	12	53	47	145	1,575	2,850.75	....	.....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....	21	21	286	517.66	....	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	....	....	....	....	....	22	22	250	452.50	....	.....
13. Apparently justifiable as City charges	1	1	....	....	....	....	2	4	55	99.55	4	$67.00
Total	32	68	34	107	57	154	174	626	6,654	$12,043.74	4	$67.00

* The figures in each column under this heading exclude the figures in the preceding columns.

TABLE IX.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class VI. Citizens for Whose Admissions the Authorization by Section 692, Subd. 7, of the City Charter Was Not Evident.

	In New York City Less Than *										Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
3. Apparently removable by State Board of Charities	2	3	....	3	1	2	....	11	57	$103.17	....	.....
4. Apparently removable by State Board of Alienists	....	....	....	....	....	....	....	....	....	.....	....	.....
5a. Apparently county or town cases with N. Y. City address	1	2	3	8	....	....	....	14	111	200.91	....	.....
5b. Apparently county or town cases without N. Y. City address	....	1	....	....	....	1	....	2	6	10.86	....	.....
5c. Apparently county or town cases giving no address	....	2	....	2	....	....	....	4	29	52.49	....	.....
6. State Poor (not in other classes)	1	1	4	8	....	....	....	14	136	246.16	....	.....
7. Apparently charges of steamship company	....	....	....	....	....	....	....	....	....	.....	....	.....
8. Without settlement in the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
9. Without settlement in N. Y. State	1	....	....	....	....	2	1	4	119	215.39	....	.....
10. State settlement unknown	....	....	....	....	....	....	....	....	....	.....	....	.....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....	1	1	2	3.62	....	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	....	....	....	....	....	5	5	15	27.15	....	.....
13. Apparently justifiable as City charges	....	....	....	....	....	....	....	....	....	.....	....	.....
Total	5	9	7	21	1	5	7	55	475	$859.75	....	.....

* The figures in each column under this heading exclude the figures in the preceding columns.

TABLE X.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Summary I. * *Classes I, II, and III—Aliens.*

	In United States Less Than †													Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	3 Years	5 Years	In U. S. 5 Years or Unknown Time	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	3	8	7	19	16	66	56	3	..	....	178	2,769	$5,011.89	8	$187.50
2. Apparently deportable by the United States	..	..	..	..	..	...	...	...	..	....	....	.....	.....	..	.....
3. Apparently removable by State Board of Charities	..	..	1	7	7	24	65	45	26	98	273	3,589	6,496.09	1	79.50
4. Apparently removable by State Board of Alienists	..	1	1	7	8	32	35	13	7	56	160	1,148	2,077.88	..	.....
5a. Apparently county or town cases with N. Y. City address	..	..	..	..	..	...	...	13	6	10	29	296	535.76	..	.....
5b. Apparently county or town cases without N. Y. City address	..	..	..	..	..	...	...	3	17	9	29	532	962.92	..	.....
5c. Apparently county or town cases giving no address	..	..	..	..	..	...	...	1	2	17	20	283	512.23	..	.....
6. State Poor (not in other classes)	..	3	11	38	40	5	2	11	13	61	184	1,812	3,279.72	..	.....
7. Apparently charges of steamship company	2	4	4	2	1	1	...	...	..	8	22	175	316.75	2	19.50
8. Without settlement in the United States	..	..	..	..	..	147	210	...	..	....	357	3,757	6,800.17	..	.....
9. Without settlement in N. Y. State	..	..	..	..	..	...	1	10	9	22	42	481	870.61	..	.....
10. State settlement unknown	..	..	..	..	..	...	...	4	12	57	73	950	1,719.50	..	.....
11. Claiming N.Y. City settlement without N. Y. City address	..	..	..	..	..	...	...	...	..	....	....	.....	.....	..	.....
12. Claiming N.Y. City settlement with address outside of N. Y. State	..	..	..	..	..	...	...	...	..	8	8	49	88.69	..	.....
13. Apparently justifiable as City charges	..	3	..	6	..	10	6	4	2	20	51	554	1,002.74	16	219.50
Total	5	19	24	79	72	285	375	107	94	366	1,426	16,395	$29,674.95	27	$506.00

* See Tables IV, V, and VI. † The figures in each column under this heading exclude the figures in the preceding columns.

TABLE XI.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Summary II. * *Classes IV, V, and VI.—Citizens.*

	In New York City Less Than †										Patients Paid For	
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	Total	Total Days Stay	Expense	Number	Amount
1. Apparently improperly admitted to the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
3. Apparently removable by State Board of Charities	23	36	14	46	25	53	43	240	2,397	$4,338.57	....	.....
4. Apparently removable by State Board of Alienists	13	8	3	6	3	3	5	41	278	503.18	....	.....
5a. Apparently county or town cases with N. Y. City address	4	3	11	26	11	39	23	117	1,235	2,235.35	....	.....
5b. Apparently county or town cases without N. Y. City address	21	37	6	13	1	5	9	92	1,109	2,007.29	....	.....
5c. Apparently county or town cases giving no address	....	5	1	4	1	2	....	13	72	130.32	....	.....
6. State Poor (not in other classes)	27	33	19	52	17	....	....	148	1,054	1,907.74	....	.....
7. Apparently charges of steamship company	....	....	....	....	....	....	....	....	....	.....	....	.....
8. Without settlement in the United States	....	....	....	....	....	....	....	....	....	.....	....	.....
9. Without settlement in N. Y. State	1	1	2	....	....	35	30	69	877	1,587.37	....	.....
10. State settlement unknown	2	10	4	17	12	53	47	145	1,575	2,850.75	....	.....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....	22	22	288	521.28	....	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	1	3	....	....	....	....	34	38	334	604.54	....	.....
13. Apparently justifiable as City charges	21	20	4	15	6	4	10	80	683	1,236.23	50	$533.00
Total	113	156	64	179	76	194	223	1,005	9,902	$17,922.62	50	$533.00

* See Tables VII, VIII, and IX. † The figures in each column under this heading exclude the figures in the preceding columns.

TABLE XII.

Bellevue Hospital.

Aliens in the United States More Than One Year and Less Than Three Years, Admitted in the Year 1912.

Class VII.

	In the United States from 1 to 2 Years			In the United States from 2 to 3 Years					
	Number Patients	Number Days Treatment	Expense	Number Patients	Number Days Treatment	Expense	Total Patients	Total Days	Total Expense
1. Apparently improperly admitted to the United States	....	.....	.....	....	.....	.....	.....	.....	.....
2. Apparently deportable by the United States	....	.....	.....	3	5	$9.05	3	5	$9.05
3. Apparently removable by State Board of Charities	227	3,365	$6,090.65	286	3,802	6,881.62	513	7,167	12,972.27
4. Apparently removable by State Board of Alienists	49	321	581.01	51	284	514.04	100	605	1,095.05
5a. Apparently county or town cases with N. Y. City address	....	.....	.....	....	.....	.....	.....	.....	.....
5b. Apparently county or town cases without N. Y. City address	....	.....	.....	....	.....	.....	.....	.....	.....
5c. Apparently county or town cases giving no address	....	.....	.....	....	.....	.....	.....	.....	.....
6. State Poor (not in other classes)	....	.....	.....	....	.....	.....	.....	.....	.....
7. Apparently charges of steamship company.	....	.....	.....	....	.....	.....	.....	.....	.....
8. Without settlement in the United States	....	.....	.....	....	.....	.....	.....	.....	.....
9. Without settlement in N. Y. State	....	.....	.....	....	.....	.....	.....	.....	.....
10. State settlement unknown	....	.....	.....	....	.....	.....	.....	.....	.....
11. Claiming N. Y. City settlement without N. Y. City address	....	.....	.....	....	.....	.....	.....	.....	.....
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	.....	.....	....	.....	.....	.....	.....	.....
13. Apparently justifiable as City charges	309	3,626	6,583.06	383	4,008	7,254.48	692	7,634	13,837.54
Total	585	7,312	$13,254.72	723	8,099	$14,659.19	1,308	15,411	$27,913.91

TABLE XIII.

Bellevue Hospital.

Non-Residents of New York City and Aliens Less than Three Years in the United States, Admitted in the Year 1912.

Grand Summary of Classes I to VII. *

	Total Number Patients	Total Days Stay	Gross Expense to City	Patients Paid For		Total Free Patients	Net Expense to City
				Number	Amount		
1. Apparently improperly admitted to the United States	178	2,769	$5,011.89	8	$187.50	170	$4,824.39
2. Apparently deportable by the United States	3	5	9.05	..	.....	3	9.05
3. Apparently removable by State Board of Charities	1,026	13,153	23,806.93	1	79.50	1,025	23,727.43
4. Apparently removable by State Board of Alienists	301	2,031	3,676.11	..	.....	301	3,676.11
5a. Apparently county or town cases with N. Y. City address	146	1,531	2,771.11	..	.....	146	2,771.11
5b. Apparently county or town cases without N. Y. City address	121	1,641	2,970.21	..	.....	121	2,970.21
5c. Apparently county or town cases giving no address	33	355	642.55	..	.....	33	642.55
6. State Poor (not in other classes)	332	2,866	5,187.46	..	.....	332	5,187.46
7. Apparently charges of steamship company	22	175	316.75	2	19.50	20	297.25
8. Without settlement in the United States	357	3,757	6,800.17	..	.....	357	6,800.17
9. Without settlement in N. Y. State	111	1,358	2,457.98	..	.....	111	2,457.98
10. State settlement unknown	218	2,525	4,570.25	..	.....	218	4,570.25
11. Claiming N. Y. City settlement without N. Y. City address	22	288	521.28	..	.....	22	521.28
12. Claiming N. Y. City settlement with address outside of N. Y. State	46	383	693.23	..	.....	46	693.23
13. Apparently justifiable as City charges	823	8,871	16,076.51	66	752.50	757	15,324.01
Total	3,739	41,708	$75,511.48	77	$1,039.00	3,662	$74,472.48

* See Tables IV to IX and XII.

TABLE XIV.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class I. Aliens Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

A. Admission	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	7	6	....	1	7	21
2. Apparently deportable by the United States.	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	23	12	3	1	1	40
4. Apparently removable by State Board of Alienists	67	13	54	17	....	151
5a. Apparently county or town cases with N. Y. City address	6	4	2	....	....	12
5b. Apparently county or town cases without N. Y. City address	7	5	....	1	....	13
5c. Apparently county or town cases giving no address	4	1	1	....	....	6
6. State Poor (not in other classes)	23	45	....	....	....	68
7. Apparently charges of steamship company..	....	2	....	....	....	2
8. Without settlement in the United States...	20	31	2	2	....	55
9. Without settlement in N. Y. State	2	3	1	....	....	6
10. State settlement unknown	....	....	....	....	....	....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	....	....	....	....	....
13. Apparently justifiable as City charges	17	12	2	1	14	46
Total	176	134	65	23	22	420

TABLE XV.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class I. Aliens Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

B. Disposition	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	17	2	....	2	....	....	....	21
2. Apparently deportable by the United States.....	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities.....	21	7	7	1	1	2	1	40
4. Apparently removable by State Board of Alienists.....	30	117	1	2	1	....	....	151
5a. Apparently county or town cases with N. Y. City address.....	12	....	....	....	....	....	....	12
5b. Apparently county or town cases without N. Y. City address.....	10	1	1	....	....	1	....	13
5c. Apparently county or town cases giving no address....	4	1	....	....	....	1	....	6
6. State Poor (not in other classes).....	56	1	....	....	....	11	....	68
7 Apparently charges of steamship company.....	2	....	....	....	....	....	....	2
8. Without settlement in the United States.....	53	....	....	....	....	2	....	55
9. Without settlement in N. Y. State.....	6	....	....	....	....	....	....	6
10. State settlement unknown....	....	....	....	....	....	....	....	....
11. Claiming N. Y. City settlement without N. Y. City address.....	....	....	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State.....	....	....	....	....	....	....	....	....
13. Apparently justifiable as City charges.....	43	3	....	....	....	....	....	46
Total.....	254	132	9	5	2	17	1	420

TABLE XVI.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class II. Aliens Whose Admissions Were Not Authorized by Section 692, Subd. 7, of the City Charter.

A. Admission	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	12	13	104	13	1	143
2. Apparently deportable by the United States.	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	17	23	158	24	....	222
4. Apparently removable by State Board of Alienists	....	3	4	....	....	7
5a. Apparently county or town cases with N. Y. City address	5	....	11	....	....	16
5b. Apparently county or town cases without N. Y. City address	....	4	8	3	....	15
5c. Apparently county or town cases giving no address	....	1	13	....	....	14
6. State Poor (not in other classes)	21	10	65	9	....	105
7. Apparently charges of steamship company	....	12	5	1	2	20
8. Without settlement in the United States	81	34	136	27	....	278
9. Without settlement in N. Y. State	5	3	25	....	....	33
10. State settlement unknown	8	4	45	5	....	62
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	....	7	1	....	8
13. Apparently justifiable as City charges	1	....	....	4	2	5
Total	150	107	581	87	5	928

TABLE XVII.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class II. Aliens Whose Admissions Were Not Authorized by Section 692, Subd. 7, of the City Charter.

B. Disposition	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	86	30	15	2	....	10	....	143
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	134	48	36	....	....	4	....	222
4. Apparently removable by State Board of Alienists	1	6	....	....	....	....	....	7
5a. Apparently county or town cases with N. Y. City address	15	....	....	....	....	1	....	16
5b. Apparently county or town cases without N. Y. City address	11	....	....	....	....	3	1	15
5c. Apparently county or town cases giving no address	12	1	....	....	....	1	....	14
6. State Poor (not in other classes)	85	12	....	....	....	7	1	105
7. Apparently charges of steamship company	16	3	....	....	....	1	....	20
8. Without settlement in the United States	258	1	....	....	....	18	1	278
9. Without settlement in N. Y. State	31	....	1	....	....	1	....	33
10. State settlement unknown	55	5	1	....	....	1	....	62
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	7	....	....	....	....	1	....	8
13. Apparently justifiable as City charges	5	....	....	....	....	....	....	5
Total	716	106	53	2	....	48	3	928

TABLE XVIII.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Class III. Aliens for Whose Admissions the Authorisation by Section 692, Subd. 7, of the City Charter Was Not Evident.

A. Admission	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	....	12	....	2	....	14
2. Apparently deportable by the United States.	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	....	10	....	1	....	11
4. Apparently removable by State Board of Alienists	....	1	....	1	....	2
5a. Apparently county or town cases with N. Y. City address	....	....	....	1	....	1
5b. Apparently county or town cases without N. Y. City address	....	1	....	....	....	1
5c. Apparently county or town cases giving no address	....	....	....	....	....	....
6. State Poor (not in other classes)	....	9	....	2	....	11
7. Apparently charges of steamship company	....	....	....	....	....	....
8. Without settlement in the United States	2	14	....	8	....	24
9. Without settlement in N. Y. State	....	1	....	2	....	3
10. State settlement unknown	1	10	....	....	....	11
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	....	....	....	....	....
13. Apparently justifiable as City charges	....	....	....	....	....	....
Total	3	58	....	17	....	78

TABLE XIX.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Class III. Aliens for Whose Admissions the Authorization by Section 692, Subd. 7, of the City Charter Was Not Evident.

B. DISPOSITION	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	4	5	1	4	....	....	....	14
2. Apparently deportable by the United States.....	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities.....	5	5	1	....	....	....	....	11
4. Apparently removable by State Board of Alienists.....	....	2	....	....	....	....	....	2
5a. Apparently county or town cases with N. Y. City address.....	1	....	....	....	....	....	....	1
5b. Apparently County or town cases without N. Y. City address.....	1	....	....	....	....	....	....	1
5c. Apparently county or town cases giving no address....	....	....	....	....	....	....	....	....
6. State Poor (not in other classes).....	11	....	....	....	....	....	....	11
7. Apparently charges of steamship company.....	....	....	....	....	....	....	....	....
8. Without settlement in the United States.....	22	1	....	....	....	1	....	24
9. Without settlement in N. Y. State.....	3	....	....	....	....	....	....	3
10. State settlement unknown...	9	2	....	....	....	....	....	11
11. Claiming N. Y. City settlement without N. Y. City address.....	....	....	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State.....	....	....	....	....	....	....	....	....
13. Apparently justifiable as City charges.....	....	....	....	....	....	....	....	....
Total.....	56	15	2	4	....	1	....	78

TABLE XX.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Class IV. Citizens Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

A. ADMISSION	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	....	....	....	....	....	....
2. Apparently deportable by the United States.	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	17	31	3	4	....	55
4. Apparently removable by State Board of Alienists	16	3	9	8	....	36
5a. Apparently county or town cases with N. Y. City address	14	25	6	5	....	50
5b. Apparently county or town cases without N. Y. City address	12	20	3	2	....	37
5c. Apparently county or town cases giving no address	....	....	....	....	....	....
6. State Poor (not in other classes)	16	35	5	3	....	59
7. Apparently charges of steamship company	....	....	....	....	....	....
8. Without settlement in the United States	....	....	....	....	....	....
9. Without settlement in N. Y. State	....	....	....	....	....	....
10. State settlement unknown	....	....	....	....	....	....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	4	7	....	....	....	11
13. Apparently justifiable as City charges	14	12	1	3	46	76
Total	93	133	27	25	46	324

TABLE XXI.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Class IV. Citizens Whose Admissions Were Authorised by Section 692, Subd. 7, of the City Charter.

B. DISPOSITION	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	....	....	....	....	....	....	....	....
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	42	4	8	....	....	1	....	55
4. Apparently removable by State Board of Alienists	3	32	....	....	1	....	....	36
5a. Apparently county or town cases with N. Y. City address	45	4	....	....	....	....	1	50
5b. Apparently county or town cases without N. Y. City address	30	6	....	....	....	1	....	37
5c. Apparently county or town cases giving no address	....	....	....	....	....	....	....	....
6. State Poor (not in other classes)	51	....	....	....	2	6	....	59
7. Apparently charges of steamship company	....	....	....	....	....	....	....	....
8. Without settlement in the United States	....	....	....	....	....	....	....	....
9. Without settlement in N. Y. State	....	....	....	....	....	....	....	....
10. State settlement unknown	....	....	....	....	....	....	....	....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	10	1	....	....	....	....	....	11
13. Apparently justifiable as City charges	69	4	1	....	1	1	....	76
Total	250	51	9	....	4	9	1	324

TABLE XXVI.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Summary I. Non-Residents Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

A. Admission	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	7	6	....	1	7	21
2. Apparently deportable by the United States	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	40	43	6	5	1	95
4. Apparently removable by State Board of Alienists	83	16	63	25	....	187
5a. Apparently county or town cases with N. Y. City address	20	29	8	5	....	62
5b. Apparently county or town cases without N. Y. City address	19	25	3	3	....	50
5c. Apparently county or town cases giving no address	4	1	1	....	....	6
6. State Poor (not in other classes)	39	80	5	3	....	127
7. Apparently charges of steamship company	....	2	....	....	....	2
8. Without settlement in the United States	20	31	2	2	....	55
9. Without settlement in N. Y. State	2	3	1	....	....	6
10. State settlement unknown	....	....	....	....	....	....
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State	4	7	....	....	....	11
13. Apparently justifiable as City charges	31	24	3	4	60	122
Totals	269	267	92	48	68	744

TABLE XXVII.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Summary I. Non-Residents Whose Admissions Were Authorized by Section 692, Subd. 7, of the City Charter.

B. DISPOSITION	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	17	2	....	2	....	....	....	21
2. Apparently deportable by the United States.....	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities.....	63	11	15	1	1	3	1	95
4. Apparently removable by State Board of Alienists.....	33	149	1	2	2	....	....	187
5a. Apparently county or town cases with N. Y. City address.....	57	4	....	....	....	....	1	62
5b. Apparently county or town cases without N. Y. City address.....	40	7	1	....	....	2	....	50
5c. Apparently county or town cases giving no address.....	4	1	....	....	....	1	....	6
6. State Poor (not in other classes).....	107	1	....	....	2	17	....	127
7. Apparently charges of steamship company.....	2	....	....	....	....	....	....	2
8. Without settlement in the United States.....	53	....	....	....	....	2	....	55
9. Without settlement in N. Y. State.....	6	....	....	....	....	....	....	6
10. State settlement unknown....	....	....	....	....	....	....	....	....
11. Claiming N. Y. City settlement without N. Y. City address.....	....	....	....	....	....	....	....	....
12. Claiming N. Y. City settlement with address outside of N. Y. State.....	10	1	....	....	....	....	....	11
13. Apparently justifiable as City charges.....	112	7	1	....	1	1	....	122
Total.....	504	183	18	5	6	26	2	744

TABLE XXVIII.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Summary II. Non-Residents Whose Admissions Were Not Authorized by Section 692, Subd. 7, of the City Charter.

A. Admission	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	12	13	104	13	1	143
2. Apparently deportable by the United States	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	24	31	304	37	....	396
4. Apparently removable by State Board of Alienists	1	3	8	....	....	12
5a. Apparently county or town cases with N. Y. City address	7	7	49	6	....	69
5b. Apparently county or town cases without N. Y. City address	2	6	49	11	....	68
5c. Apparently county or town cases giving no address	....	1	22	....	....	23
6. State Poor (not in other classes)	25	15	119	21	....	180
7. Apparently charges of steamship company	....	12	5	1	2	20
8. Without settlement in the United States	81	34	136	27	....	278
9. Without settlement in N. Y. State	7	13	74	4	....	98
10. State settlement unknown	21	21	145	20	....	207
11. Claiming N. Y. City settlement without N. Y. City address	2	....	16	3	....	21
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	....	25	5	....	30
13. Apparently justifiable as City charges	2	....	....	1	6	9
Total	184	156	1,056	149	9	1,554

TABLE XXIX.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Summary II. Non-Residents Whose Admissions Were Not Authorized by Section 692, Subd. 7, of the City Charter.

B. DISPOSITION	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	86	30	15	2	....	10	....	143
2. Apparently deportable by the United States.....	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities.....	259	66	66	....	....	5	....	396
4. Apparently removable by State Board of Alienists.....	1	11	....	....	....	....	....	12
5a. Apparently county or town cases with N. Y. City address.....	62	3	....	....	....	4	....	69
5b. Apparently county or town cases without N. Y. City address.....	55	4	....	....	....	8	1	68
5c. Apparently county or town cases giving no address.....	20	2	....	....	....	1	....	23
6. State Poor (not in other classes).....	153	15	....	....	....	11	1	180
7. Apparently charges of steamship company.....	16	3	....	....	....	1	....	20
8. Without settlement in the United States.....	258	1	....	....	....	18	1	278
9. Without settlement in N. Y. State.....	93	....	1	....	....	4	....	98
10. State settlement unknown....	177	13	1	....	....	16	....	207
11. Claiming N. Y. City settlement without N. Y. City address.....	17	3	....	....	....	1	....	21
12. Claiming N. Y. City settlement with address outside N. Y. State.....	27	....	....	....	....	2	1	30
13. Apparently justifiable as City charges.....	8	....	....	....	....	1	....	9
Total.....	1,232	151	83	2	....	82	4	1,554

TABLE XXX.

Bellevue Hospital.

Non-Residents of New York City Admitted in the Year 1912.

Summary III. Non-Residents for Whose Admissions the Authorization by Section 692, Subd. 7, of the City Charter Was Not Evident.

A. Admission	By Bellevue Ambulances	By Other Ambulances	Walked	By Other or Unknown Means	Patients Paid For	Total
1. Apparently improperly admitted to the United States	....	12	....	2	....	14
2. Apparently deportable by the United States.	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	1	19	....	2	....	22
4. Apparently removable by State Board of Alienists	....	1	....	1	....	2
5a. Apparently county or town cases with N. Y. City address	1	7	....	7	....	15
5b. Apparently county or town cases without N. Y. City address	....	3	....	....	....	3
5c. Apparently county or town cases giving no address	....	4	....	....	....	4
6. State Poor (not in other classes)	....	18	....	7	....	25
7. Apparently charges of steamship company	....	....	....	....	....	....
8. Without settlement in the United States	2	14	....	8	....	24
9. Without settlement in N. Y. State	....	4	....	3	....	7
10. State settlement unknown	1	10	....	....	....	11
11. Claiming N. Y. City settlement without N. Y. City address	....	....	....	1	....	1
12. Claiming N. Y. City settlement with address outside of N. Y. State	....	3	....	2	....	5
13. Apparently justifiable as City charges	....	....	....	....	....	....
Total	5	95	....	33	....	133

TABLE XXXI.

BELLEVUE HOSPITAL.

NON-RESIDENTS OF NEW YORK CITY ADMITTED IN THE YEAR 1912.

Summary III. Non-Residents for Whose Admissions the Authorization by Section 692, Subd. 7, of the City Charter Was Not Evident.

B. DISPOSITION	Discharged	Transferred	Removed by State Board of Charities	Removed by United States	Removed by State Board of Alienists	Died	Still in Hospital	Total
1. Apparently improperly admitted to the United States.	4	5	1	4	....	....	....	14
2. Apparently deportable by the United States	....	....	....	....	....	....	....	....
3. Apparently removable by State Board of Charities	11	7	3	....	....	1	....	22
4. Apparently removable by State Board of Alienists	....	2	....	....	....	....	....	2
5a. Apparently county or town cases with N. Y. City address	11	1	....	....	....	3	....	15
5b. Apparently county or town cases without N. Y. City address	3	....	....	....	....	....	....	3
5c. Apparently county or town cases giving no address	3	....	....	....	....	1	....	4
6. State Poor (not in other classes)	24	....	....	....	....	1	....	25
7. Apparently charges of steamship company	....	....	....	....	....	....	....	....
8. Without settlement in the United States	22	1	....	....	....	1	....	24
9. Without settlement in N. Y. State	7	....	....	....	....	....	....	7
10. State settlement unknown	9	2	....	....	....	....	....	11
11. Claiming N. Y. City settlement without N. Y. City address	1	.....	..	....	....	....	....	1
12. Claiming N. Y. City settlement with address outside of N. Y. State	5	....	....	....	....	....	....	5
13. Apparently justifiable as City charges	....	....	....	....	....	....	....	....
Total	100	18	4	4	....	7	....	133

XXXV.

Bellevue Hospital.

Admissions of Non-Residents of New York City in 1912, Classified According to Length of Stay in the City.

	In City Less Than *							
	1 Day	3 Days	1 Week	1 Month	2 Months	6 Months	1 Year	Total
Aliens:								
Class I.....	106	26	25	46	51	107	59	420
Class II.....	85	30	53	124	121	324	191	928
Class III.....	6	7	7	13	13	22	10	78
Citizens:								
Class IV.....	172	13	24	51	15	31	18	324
Class V.....	145	30	53	106	58	168	66	626
Class VI.....	15	6	7	11	1	10	5	55
Total.....	529 21.8%	112 4.6%	169 6.9%	351 14.4%	259 10.7%	662 27.2%	349 14.4%	2,431 100%
Cumulative Totals.....	529	641	810	1,161	1,420	2,082	2,431	.....
Cumulative Percentages.....	21.8%	26.4%	33.3%	47.7%	58.4%	85.6%	100%	.....

* In each column all figures (except the cumulative totals and cumulative percentages) exclude the figures in the preceding columns.

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.	73
.	18
.	56
.	213
.	16
.	85
.	75
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Admissions

ALIENS:

Class I...

Class II..

Class III.

CITIZENS:

Class IV..

Class V...

Class VI..

Total.

Cumulative
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Cumulative 1
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* In each c
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TABLE XXXVI.

BELLEVUE HOSPITAL.

NON-RESIDENT CITIZENS ADMITTED IN 1912.

Classified According to the Apparent Contraction of Ailment Before or After Coming to New York City.

	Class IV *			Class V *			Class VI *			Total		
	Before	After	Indefinite	Before	After	Indefinite	Before	After	Indefinite	Before	After	Indefinite
Acute† Gonorrhea	2	3	...	5	27	...	..	3	..	7	33	...
Acute Diseases of Heart and Circulatory System	3	1	...	1	4	...	..	..	..	4	5	...
Acute Diseases of Male Genital Organs	5	1	...	8	8	...	1	1	..	14	10	...
Acute Diseases of Female Genital Organs	..	..	...	1	8	...	..	..	..	1	8	...
Acute Rheumatism	2	..	...	1	9	...	..	..	..	3	9	...
Malaria	1	..	...	4	9	...	1	..	..	6	9	...
Acute Diseases of Respiratory System	..	..	...	2	19	...	1	..	..	3	19	...
Acute Diseases of Nervous System	8	2	...	2	3	...	..	..	..	10	5	...
Typhoid Fever	..	..	...	...	1	...	..	..	..	...	1	...
Other Epidemic Diseases	..	..	...	4	9	...	..	..	..	4	9	...
Chronic Rheumatism	1	..	...	2	2	...	..	..	..	3	2	...
Acute Syphilis	3	..	...	14	9	...	1	..	..	18	9	...
Chronic Diseases of Male Genital Organs	..	..	...	5	1	...	..	..	..	5	1	...
Chronic Diseases of Female Genital Organs	2	..	...	7	8	...	..	..	..	9	8	...
Tuberculosis of Lungs	6	1	...	39	5	...	7	1	..	52	7	...
Other Tubercular Diseases	..	..	...	5	4	...	..	..	..	5	4	...
Drug Habit	4	1	...	12	2	...	1	..	..	17	3	...
Chronic Diseases of Respiratory System	..	1	...	...	...	...	..	..	..	...	1	...
Chronic Diseases of Heart and Circulatory System	20	1	...	29	3	...	5	..	..	54	4	...
Chronic Diseases of Digestive System	2	..	...	8	2	...	..	1	..	10	3	...
Chronic Syphilis	..	..	...	7	1	...	1	..	..	8	1	...
Parturition	4	..	...	24	2	...	2	..	..	30	2	...
Cancer and Tumor	1	..	...	4	...	...	..	..	..	5	...	...
Chronic Alcoholism	11	1	...	10	...	...	2	..	..	23	1	...
Epilepsy	4	..	...	3	...	...	..	..	..	7	...	...
Other Diseases of Nervous System	8	..	...	8	...	...	1	..	..	17	...	...
Insanity	..	..	66	...	...	7	..	..	..	...	...	73
Hernia	..	..	4	...	...	14	..	..	..	...	...	18
Acute Diseases of Digestive System	..	..	7	...	...	46	..	..	3	...	...	56
Alcoholism	..	..	75	...	...	123	..	..	15	...	...	213
Pregnancy	..	..	2	...	...	14	..	..	..	...	...	16
Causes not elsewhere specified	..	..	18	...	...	63	..	..	4	...	...	85
Traumatism, Burns, etc.	..	..	53	...	...	18	..	..	4	...	...	75
	87	12	225	205	136	285	23	6	26	315	154	536

* The constitution of Classes IV, V, and VI will be found by referring to Tables VII, VIII, and IX.

† Acute here and elsewhere in this table is applied to all diagnoses not shown to be chronic.

TABLE XXXVII.

Bellevue Hospital.

Admissions of Non-Residents of New York City in 1912.

This table shows the hospital diagnoses of patients indicated by the records as not having had a legal settlement in New York City.

The numbers and percentages of patients having certain diagnoses are shown for aliens and for citizens separately; and the numbers only for the following subdivisions under aliens and under citizens: Classes I and IV, those whose admissions were authorized by Section 692, Subdivision 7, of the City Charter; Classes II and V, those whose admissions were not authorized; Classes III and VI, those for whose admissions the authorization was not evident.

	Aliens			Total		Citizens			Total	
	Class I	Class II	Class III	Total	Per Cent.	Class IV	Class V	Class VI	Total	Per Cent.
Tuberculosis of the Lungs.	14	103	4	121	8.5	7	44	8	59	5.9
Other Tubercular Diseases	...	11	1	12	0.8	...	9	...	9	0.9
Gonorrhea	2	3	...	5	0.4	5	32	3	40	4.0
Syphilis	6	32	1	39	2.8	3	31	2	36	3.6
Chronic Diseases of Male Genital Organs	...	1	...	1	0.1	...	6	...	6	0.6
Chronic Diseases of Female Genital Organs	...	7	...	7	0.5	2	15	...	17	1.7
Insanity	166	16	2	184	12.9	66	7	...	73	7.3
Epilepsy	...	2	...	2	0.2	4	3	...	7	0.7
Other Diseases of Nervous System	8	18	2	28	2.0	8	8	1	17	1.7
Hernia	1	19	...	20	1.4	4	14	...	18	1.8
Chronic Alcoholism	9	10	...	19	1.3	12	10	2	24	2.4
Chronic Rheumatism	2	4	...	6	0.4	1	4	...	5	0.5
Chronic Diseases of Respiratory System	1	7	1	9	0.6	1	...	...	1	0.1
Chronic Diseases of Heart and Circulatory System.	2	18	4	24	1.7	21	32	5	58	5.8
Chronic Diseases of Digestive System	1	4	...	5	0.4	2	10	1	13	1.0
Cancer and Tumor	3	9	1	13	0.9	1	4	...	5	0.5
Typhoid Fever	...	7	...	7	0.5	...	1	...	1	0.1
Other Epidemic Diseases	...	...	...	...	...	...	13	...	13	1.0
Malaria	1	15	4	20	1.4	1	13	1	15	1.5
Alcoholism and Drug Habit	41	63	13	117	8.0	75	123	15	213	22.0
Parturition	3	38	...	41	2.9	4	26	2	32	3.0
Pregnancy	3	17	...	20	1.4	2	14	...	16	1.6
Erysipelas	11	50	10	71	4.9	...	...	...	...	...
Cellulitis	...	14	2	16	1.1	...	...	...	...	...
Acute Rheumatism	4	35	7	46	3.2	2	10	...	12	1.0
Acute Diseases of Male Genital Organs	8	66	3	77	5.3	6	16	2	24	2.4
Acute Diseases of Female Genital Organs	1	15	2	18	1.3	...	9	...	9	0.9
Acute Diseases of Nervous System	2	...	...	2	0.2	10	5	..	15	1.5
Acute Diseases of Respiratory System	3	66	...	69	4.8	...	21	1	22	2.0
Acute Diseases of Heart and Circulatory System.	4	5	...	9	0.6	4	5	...	9	0.9
Acute Diseases of Digestive System	7	92	2	101	7.3	12	60	4	76	7.6
Causes not elsewhere specified	30	127	8	154	10.8	18	63	4	85	8.5
Traumatism, Burns, etc.	98	54	11	163	11.4	53	18	4	75	7.5
Total	420	928	78	1,426	100.0	324	626	55	1,005	100.0

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mmigration Law;
prior to landing;
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latorily excludable
tified by the Med-
ion.

Patients affecting a living."	Total
	10
	15
	81
	2
	1
	1
	1
	1
	26
	14
	6
	5
	1
	1
	3
	3
	1
	1
	1
	1
	1
	1
	2
	1
	1
	1
	1
	1
	1
	185
	100%

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Subdivision 7, of
Classes III and

Tuberculosis of	
Other Tubercula	
Gonorrhea	
Syphilis	
Chronic Diseases	
Genital Organ	
Chronic Diseas	
male Genital	
Insanity	
Epilepsy	
Other Diseases	
System	
Hernia	
Chronic Alcohol	
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tive System	
Cancer and Tu	
Typhoid Fever	
Other Epidemic	
Malaria	
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Habit	
Parturition	
Pregnancy	
Erysipelas	
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Causes not elsev	
fied	
Traumatism, B	
Total	

TABLE XLII.

Bellevue Hospital.

Aliens Admitted from May 19, 1913, to June 18, 1913, as Public Charges from Causes Existing Prior to Landing in the United States.

This table shows the causes of the dependence of the patients that were classified in Table XXXVIII of this Report under Class 1 as: 1—Aliens in the United States in violation of the Federal Immigration Law; 2—Aliens deportable under the Federal Immigration Law; 3a—Aliens deportable under the State Charities Law from causes existing prior to landing; 4a—Aliens deportable (with consent) under the State Insanity Law from causes existing prior to landing.

In this table the diagnoses are separated into those of aliens that are mandatorily excludable and must be deported under the Immigration Law, and those that may be certified by the Medical Officers as "affecting ability to earn a living" which may cause deportation.

	Diagnoses of Patients Mandatorily Excludable	Diagnoses of Patients Certifiable as "affecting ability to earn a living."	Total
Pulmonary Tuberculosis	10	..	10
Venereal Diseases	15	..	15
Insane	81	..	81
Epilepsy	2	..	2
Urethral Fistula	..	1	1
Hypospadias	..	1	1
Salpingitis	..	1	1
Hernia	..	1	1
Chronic Alcoholism	..	26	26
Chronic Cardiac Disease	..	14	14
Cnronic Gastritis	..	6	6
Joint Affections	..	5	5
Chronic Arthritis	..	1	1
Acute Articular Rheumatism	..	1	1
Chronic Otitis Media	..	3	3
Pregnancy	..	3	3
Childbirth	..	1	1
Abortion	..	1	1
Exophthalmic Goiter	..	1	1
Malignant Tumor	..	1	1
Chronic Emphysema	..	1	1
Empyema	..	1	1
Imbecile	2	..	2
Congenital Malformation of Toe	..	1	1
Malaria	..	1	1
Asthma	..	1	1
Erysipelas	..	1	1
Carbuncle	..	1	1
Acute Alcoholism	..	1	1
Total	110	75	185
	59.5%	40.5%	100%

TABLE XLIII.

Bellevue Hospital.

Aliens Admitted from May 19, 1913, to June 18, 1913, as Public Charges Whose Causes of Dependence Probably Could Have Been Detected With Proper Facilities at the Time of Landing in the United States.

This table represents those patients among the 185 cases that were public charges from causes existing prior to landing shown in Table XLII, whose causes of dependence could probably have been detected had adequate facilities existed for their thorough examination at the time of landing.

These cases are arranged according to conditions attending the landing of the patients in this country to which the failure to prevent their presence as subsequent public charges may reasonably be attributed.

CONDITIONS WHICH MAY HAVE BEEN RESPONSIBLE FOR THE FAILURE IN PREVENTING PUBLIC DEPENDENCE.	Number of patients
(1) Lack of a quiet place for the examination of heart and lungs, and lack of facilities for undressing immigrants	40
(2) Lack of medical interpreters and lack of facilities for detaining mental suspects	40
(3) Lack of place in which to properly examine discharged seamen	5
(4) Lack of oversight by the immigration authorities of ships' crews and the ease of desertion	6
(5) Difficulty of detecting cases of epilepsy	2
(6) Appearance possibly trivial at entry (case of congenital malformation of toe)	1
(7) Transfer of one patient for childbirth from a private hospital before technically landed	1
(8) Apparent carelessness on part of medical examiners	10
Total	105

The above 105 cases were composed as follows:

Mandatorily excludable,		
Insane	28	
Venereal Diseases (active stage)	15	
Pulmonary Tuberculosis	8	
Epilepsy	2	
Imbeciles	2	55
Certifiable as "affecting ability to earn a living"		48
Appearance possibly trivial at entry		1
Public charge before technically landed		1
		105

TABLE XLIV.

ALIENS, NON-RESIDENTS, AND STATE POOR REMOVED FROM NEW YORK CITY INSTITUTIONS BY THE STATE BOARD OF CHARITIES IN THE YEAR ENDED SEPTEMBER 30, 1912.

Key: S.B.C. Removed by State Board of Charities.
U.S. Removed by United States Immigration Service.
To C. Removed to other Countries.
To S. Removed to other States.
B.D.A. Bureau of Dependent Adults.

	S.B.C. To S.	S.B.C. To C.	U.S. To C.	Total To C.	Total Removed	Per Cent. of Grand Total	Class Total	Class Per Cent.
DEPARTMENT OF PUBLIC CHARITIES:								
Metropolitan Hospital	129	157	13	170	299	22.0	...	.....
City Hospital	111	103	8	111	222	16.4	...	.....
City Home, Manhattan	67	86	8	94	161	11.9	...	.....
Randalls Island	1	3	0	3	4	0.3	...	.....
B.D.A. Manhattan	5	0	0	0	5	0.4	...	.....
Municipal Lodging House	79	50	0	50	129	9.5	...	.....
Kings County Hospital	16	20	2	22	38	2.9	...	.....
Cumberland Street Hospital	3	0	0	0	3	0.2	...	.....
City Home, Brooklyn	2	6	0	6	8	0.6	...	.....
B.D.A. Brooklyn	0	8	0	8	8	0.6	877	64.8
BELLEVUE AND ALLIED HOSPITALS:								
Bellevue Hospital	112	83	7	90	202	14.9	...	.....
Gouverneur Hospital	6	15	0	15	21	1.5	...	.....
Fordham Hospital	0	5	0	5	5	0.4	...	.....
Harlem Hospital	4	0	0	0	4	0.3	232	17.1
DEPARTMENT OF HEALTH:								
Riverside Hospital	0	7	0	7	7	0.5	...	.....
Willard Parker Hospital	0	2	0	2	2	0.2	9	0.7
STATE INSTITUTIONS:								
Central Islip	0	14	0	14	14	1.1	...	.....
Manhattan State Hospital	0	6	1	7	7	0.5	21	1.6
PRIVATE INSTITUTIONS:								
1. Hospitals	34	63	3	66	100	7.4	...	.....
2. Homes	17	12	2	14	31	2.3	...	.....
3. Societies	28	21	0	21	49	3.6	...	.....
4. Dispensaries	2	1	0	1	3	0.2	183	13.5
UNKNOWN INSTITUTIONS	5	26	0	26	31	2.3	31	2.3
Total	621	688	44	732	1,353	100.0		100.0

TABLE XLV.

Department of Public Charities.

Aliens, Non-Residents, and State Poor Reported Upon by the Bureaus of Dependent Adults, Manhattan.

	Committed to City Home, Manhattan		Returned to Commissioner of Immigration
	STATE POOR	ALIENS	ALIENS
1902	1,069	....	1,137
1903	974	....	861
1904	263	....	328
1905	92	....	43
1906	111	....	....
1907	2,005	....	....
1908	206	1,203	....
1909	293	1,256	....
1910	772	1,556	....
1911	693	1,462	....
1912	....	....	....

TABLE XLVI.

State Poor in State Almshouses in New York City.

Year Ending September 30	City Home, Brooklyn		City Home, Manhattan	
	Number Committed During Year	Whole Number Supported	Number Committed During Year	Whole Number Supported
1902	681	710	634	634
1903	66	72	933	970
1904	40	46	532	562
1905	48	53	126	134
1906	47	49	137	137
1907	56	62	198	200
1908	20	21	234	241
1909*	...	...	...	...
1910	44	44	164	166
1911	20	21	203	204

* The figures for this year were not published in the Annual Report of the State Board of Charities.

TABLE XLVII.

STATE BOARD OF CHARITIES.

DISBURSEMENTS OF THE DEPARTMENT OF STATE AND ALIEN POOR FOR SALARIES AND FOR THE STATE POOR.

	Salaries Paid to Staff	Maintenance of State Poor in Entire State	Maintenance of State Poor in N. Y. City	Per Cent. of Maintenance Paid to N. Y. City	Removals of State Poor from Entire State
1902	$11,572.50	$12,913.82	$5,516.44	43.0	$9,062.54
1903	12,800.00	13,068.17	5,149.64	39.0	7,627.20
1904	12,937.74	11,236.55	3,971.78	36.0	5,259.39
1905	11,297.88	8,596.26	1,289.63	15.0	2,338.57
1906	13,373.67	8,678.89	890.17	10.0	4,369.67
1907	11,879.39	8,446.65	1,118.20	13.0	2,248.16
1908	13,478.64	8,913.86	1,268.93	14.0	3,179.76
1909	14,940.00	7,261.21	890.70	12.0	1,595.36
1910	17,060.00	6,043.67	1,107.50	18.0	1,923.49
1911	19,614.16	5,227.01	724.82	14.0	2,816.36
1912	28,060.00	.....*	606.79	....	.....*

* Not yet itemized in report of State Board of Charities.

TABLE XLVIII.

REMOVALS OF STATE POOR FROM NEW YORK STATE BY THE STATE BOARD OF CHARITIES.

	From Entire State, Including New York City	From City Home, Flatbush	From City Home, Manhattan	From Both City Homes	City Homes, Per Cent. of State
1902	931	310	458	768	82.0
1903	809	14	653	667	82.0
1904	496	17	335	352	71.0
1905	235	17	83	100	42.0
1906	256	10	101	111	43.0
1907	276	19	132	151	55.0
1908	280	10	117	127	45.0
1909	292	not given	not given	not given	....
1910	219	15	93	108	49.0
1911	300	11	112	123	41.0
Total (Omitting 1909)	3,802	423	2,084	2,507	66.0

TABLE XLIX.

Commitments of State Poor to the City Home, Manhattan.

Key: B.D.A. Bureau of Dependent Adults, Manhattan.
S.B.C. State Board of Charities.

	B.D.A. Report	S.B.C. Report	Excess B.D.A. over S.B.C. Report	Excess S.B.C. over B.D.A. Report
1902	1,069	634	435	....
1903	974	933	41	....
1904	263	532	....	269
1905	92	126	....	34
1906	111	137	....	26
1907	2,005	198	1,807	....
1908	206	234	....	28
1909	293	not given	....	....
1910	772	164	608	....
1911	693	203	490	....
Total (Omitting 1909)	6,185	3,161		

TABLE L.

New York City Home, Manhattan.

Disposition of Alleged State Poor Entered on the State Register from October 1, 1911, to September 30, 1912.

Removed to other countries	7
Removed to other states	78
Discharged to "care of self"	36
Discharged as not proper State cases	51
Discharged as otherwise provided for	6
Returned to ship	1
Disposition unknown	1
Absconded	1
	181

TABLE LI.

State Poor Maintained in the New York City Home, Manhattan.

	S.B.C. Report Number Maintained	D.P.C. Report S.B.C. Payment	Average Days Stay Per Case	D.P.C. Report Number Maintained	*Estimated Current Expense to City	Estimated Current Loss to City	Estimated Current Gain to City
1902	634	$2,623.22	12	1,069	$3,861.23	$1,238.01	.....
1903	970	4,143.92	12	1,028	3,821.69	.....	$322.23
1904	562	3,241.78	16	344	1,892.82	.....	1,348.96
1905	134	867.49	18	100	610.38	.....	257.11
1906	137	524.10	11	111	457.00	.....	67.10
1907	200	778.92	11	2,007	8,420.17	7,641.25	.....
1908	241	1,126.79	13	213	981.89	.....	144.90
1909	not given	890.70	..	295	.....	.....	.....
1910	166	874.64	15	774	4,906.39	4,031.75	.....
1911	204	620.54	8	694	2,285.20	1,664.66	.....
		$15,692.10				$14,575.67	$2,140.30
						2,140.30	
Total Net Current Loss to City						$12,435.37	

Ratio of Total Net Current Loss to Total Payments, 73 to 100.

* Estimated on average days stay for cases paid for by the State Board of Charities and the Department of Charities' per capita per diem for dependent expense (including administration and general current expenses) for each year. Corporate stock expenditures are not included.

TABLE LII.

INSTITUTIONS HARBORING THE STATE POOR ENTERED ON THE STATE REGISTER AT THE NEW YORK CITY HOME, MANHATTAN, FOR WHOM BILLS WERE RENDERED TO THE STATE BOARD OF CHARITIES, FROM OCT. 1, 1911, to SEPT. 30, 1912.

City Home	35
Municipal Lodging House	11
City Hospital	37
Metropolitan Hospital	28
Bellevue Hospital	2
Misericordia Hospital	1
Society for Prevention of Cruelty to Children	1
Unknown	11
	126

TABLE LIII.

NEW YORK CITY HOME, MANHATTAN.

Disposition of Alleged Aliens, Non-Residents, and State Poor Reported by the Bureau of Dependent Adults, Manhattan, to the State Board of Charities in 1912.

Deported to other countries	19
Removed to other states	24
Discharged to State Agent	39
Discharged by order of State Agent	15
Discharged with no reason given	11
Returned to ship	1
Died	1
Still in Home January 8, 1913	4
Not on the Register at the City Home	19
	133

TABLE LIV.

METROPOLITAN HOSPITAL.

DEPORTATION CASES IN 1911.

(*From 1911 Annual Report of the Department of Public Charities.*)

Remaining January 1, 1911	150	
Admitted during Year 1911	1,434	1,584
Discharged during Year 1911	1,073	
Deported during Year 1911	269	
Died during Year 1911	92	
Transferred to City Home	2	
Transferred to Bellevue Hospital	2	
Eloped	1	
Remaining December 31, 1911	145	1,584

Discharged cases were four times the number deported.
Excluding those who died, only 18% of the deportable cases were deported.

TABLE LV.

Department of Public Charities.

Dependents Reported by Bureaus of Dependent Adults.

Removals by the State Board of Charities and the United States Government.

BROOKLYN BUREAU.

	Reported to S.B.C.	Removed by S.B.C.	Percentage Removed of Reported
1906	98	41	42
1907	161	41	25
1908	204	147	72
1909	178	22	12
1910	195	76	31
1911	125	72	58
Total	961	399	41

APPENDIX

TO

ALIENS, NON-RESIDENTS, AND STATE POOR.

PATIENTS ADMITTED TO BELLEVUE HOSPITAL FROM MAY 19 TO JUNE 18, 1913

The following digests are from the histories of alien patients admitted to Bellevue Hospital during a period of 31 days. These histories were classified after physical examination and investigation of the patients and medical records by the physicians and investigators in the service of the Committee.

The classification separates aliens from all other patients, and the aliens are further subdivided into:

CLASS I-1. Aliens in the United States in violation of the Federal Immigration Law.
CLASS I-2. Aliens deportable under the Federal Immigration Law.
CLASS I-3. Aliens deportable under the State Charities Law:
- a. From causes existing prior to landing.
- b. From causes whose priority to landing is not certain.
- c. From causes existing subsequent to landing.

CLASS I-4. Aliens deportable (with consent) under the State Insanity Law:
- a. From causes existing prior to landing.
- b. From causes whose priority to landing is not certain.
- c. From causes existing subsequent to landing.

CLASS I-5. Aliens whose deportation might not have been humane:
- a. Likely to become chronic or recurrent dependents.
- b. Seemingly temporary dependents.

CLASS I—1. Aliens in the United States in Violation of the Federal Immigration Law.

CASE 1. A native of Austria. Age 24 years. A single man.

This patient was a deserted seaman, in New York City only 2½ months, and previously had resided 4 years in Philadelphia. He was employed in a factory, and also had taken positions as a waiter in restaurants. He was suffering from chronic pulmonary tuberculosis, with a history of existing conditions prior to admission to the United States. The prognosis was unfavorable.

CASE 2. A native of Italy. Age 24 years. A single woman.

This patient landed at New York in 1912. She was a prostitute. She was admitted to the Hospital for psychopathic observation and was deported by the United States Immigration Service.

CASE 3. A native of Hungary. Age 22 years.

This patient claimed to be a divorced woman. She landed at New York in August, 1911. She was suffering from venereal disease of 3 years existence, and had been admitted to the same Hospital in the preceding month. She was a resident of New York only 4½ months, and previously had lived in Chicago. Her parents were living in Europe, but she was without relatives in this country. The prognosis was unfavorable.

CASE 4. A native of England. Age 39 years. A married man. A seaman.

This patient landed at New York in 1900, and had been engaged as a porter after landing. He was suffering from suppurative pleurisy. He had an operation in another hospital the same month he was admitted to Bellevue Hospital. He earned $50 a month when working, but had been unemployed for 7 weeks prior to admission. A wife and 6 children were dependent upon him. The prognosis was unfavorable.

CASE 5. A native of Austria. Age 20 years. A single man.

This patient landed at New York in March, 1913. He was suffering from chronic cardiac valvular disease and acute multiple arthritis, with history of cardiac disease and gonorrheal infection prior to landing. He was a deserted seaman who had taken up the occupation of a porter on shore. The prognosis was unfavorable.

CASE 6. A native of Austria. Age 22 years. A single man.

This patient landed at New York in March, 1910. He was a deserted seaman, who had taken up the occupation of a railroad employee. Diagnosis, facial erysipelas. The prognosis was favorable.

CASE 7. A native of Germany. Age 62 years. A single man.

This patient landed at New York April 1, 1913. Previous to his arrival in the United States he had resided in Panama. Six weeks after landing he was taken ill and was admitted to the Hospital. After admission to the Hospital he was transferred to the psychopathic observation ward. The diagnosis was cerebro-spinal syphilis and general paresis, existing prior to landing. He had no money to pay for his maintenance at the Hospital, and also had no relatives in this country who could assist him. He was discharged in an unimproved condition. The prognosis was unfavorable.

CASE 8. A native of Austria. Age 27 years. A single woman.

This patient landed September 2, 1912, and settled in New York City. She came to the Hospital from the Coroner's Office as a prisoner. She had murdered her newly-born child and attempted to commit suicide. From the medical history it is evident that this patient became pregnant prior to landing. The prognosis was unfavorable.

CASE 9. A native of Italy. Age 24 years. A married woman.

This patient came to the United States from Canada in December, 1911. She was admitted to the Hospital suffering from chronic salpingitis, and was discharged in an unimproved condition. The medical records indicate that her illness began 3 years before. Her husband was a saloon keeper, but business brought in very little. She had worked as a finisher of waists when not ill. The prognosis was unfavorable.

CASE 10. A native of Turkey. Age 25 years. A single man.

This patient landed at New York in February, 1913. About 4 months thereafter he had a hemorrhage and was taken to the Hospital. The diagnosis was chronic pulmonary tuberculosis. The condition of his lungs indicated that he had had this disease prior to landing. He had no savings, and his brother, the only relative he had in this City, was able to give him very little assistance. The prognosis was unfavorable.

CASE 11. A native of Argentine Republic. Age 26 years. A single man.

This patient landed at New York in December, 1912. His medical history shows that he had been suffering from pulmonary tuberculosis prior to his admission to the United States. The diagnosis of his illness was pulmonary tuberculosis and manic depressive insanity. The prognosis was unfavorable. He was deported by the United States Immigration Service.

CASE 12. A native of the British West Indies. Age 30 years. A single man.

This patient was a seaman, who deserted his vessel in May, 1913, and settled in New York City, in violation of the regulations of the United States Department of Labor. His medical history recorded 3 or 4 attacks of gonorrhea prior to his arrival in the United States. He was treated at the Hospital for acute bronchitis and was discharged as cured. This man had no definite occupation and no savings. The prognosis was unfavorable.

CASE 13. A native of British West Indies. Age 23 years. A single man.

This patient was a seaman who deserted at Tampa, Florida, in June, 1910, thus gaining admission to the United States in violation of the regulations of the United States Department of Labor. He came to New York City on the 20th of June, 1912, and was employed as drill man in the subway. His medical history shows that he had this disease prior to landing. The diagnosis of his condition was systemic syphilis. He was a drinking man, who spent all his earnings. He had been ill off and on for over a year. He had no relatives in this country. His parents lived in the West Indies. The prognosis was unfavorable.

CASE 14. A native of England. Age 30 years. A single man.

This patient was a seaman. He deserted in 1907 and took up his residence in New York City, in violation of the regulations of the United States Department of Labor. His diagnosis was malnutrition, and his general condition was very poor. On admission to the Hospital he had had a carbuncle of 18 weeks existence. He had been out of work for some time and had no savings. He also had no relatives able to assist him. As he was in need of a prolonged period of convalescent care he was transferred to another hospital. The prognosis for robust health was unfavorable.

CASE 15. A native of England. Age 20 years. A single man.

This patient was a seaman. He landed at New York May 31, 1913, and was to sail in a few days. On June 2, 1913, he was admitted to the Hospital suffering from syphilis, which was contracted prior to his arrival in the United States. He had previously been admitted to the same Hospital for acute gonorrhea. The prognosis was unfavorable.

CASE 16. A native of Austria. Age 17 years. A single woman.

This patient landed at New York May 25, 1913. She was admitted for psychopathic observation and declared insane. The medical history showed that this condition existed for 2 years prior to landing. The prognosis was unfavorable.

CASE 17. A native of Italy. Age 34 years. A married man.

This patient landed at New York October 17, 1912. The medical history shows that he had a case of incipient pulmonary tuberculosis of 7 months existence. After a short stay in the general medical ward he was transferred to the psychopathic ward for observation, and his case was diagnosed as allied to manic depressive insanity. He was discharged in the care of his mother-in-law, who, however, could not pay for his maintenance at the Hospital. This man had a wife and 2 dependent children in Italy, who were to join him here in the fall. The prognosis was unfavorable.

CASE 18. A native of Austria. Age 40 years.

This patient landed at New York in 1910. He was admitted for psychopathic observation. The diagnosis in this case was psychopathic disorder, existing prior to landing. He was deported on June 17, 1913, by the United States Immigration Service.

CASE 19. A native of England. Age 26 years. A married man.

This patient was employed as cook on a steamship. He came to New York June 6, 1913, and was admitted to the Hospital by ambulance June 7, 1913. He was suffering from venereal infection of at least 10 days existence. He had no savings and could not pay for his maintenance at the Hospital. The prognosis was unfavorable.

CASE 20. A native of Cuba. Age 20 years. A single man.

This patient landed at New York in May, 1912. His medical history shows that he had syphilis contracted 3 years prior to landing. He was admitted to the Hospital to be treated for acute gonorrhea of 3 weeks standing. His parents were in Europe and he was alone in this country. He earned about $8.00 a week when working and at the time of admission had no savings. The prognosis was unfavorable.

CASE 21. A native of Austria. Age 35 years. A single man.

This patient landed at New York March 11, 1911. He was admitted to the Hospital to be treated for shock and internal injury which he sustained in an accident. His medical history revealed a case of pulmonary tuberculosis, which condition existed prior to landing. He had no relatives in the United States and had no savings. He had earned about $4.00 a week. The prognosis was unfavorable.

CASE 22. A native of Austria. Age 20 years. A single man.

This patient landed at New York March 2, 1913, and lived 1 month thereafter in New Jersey. His medical history showed an attack of gonorrhea 6 months prior to landing in the United States. He was admitted to the Hospital suffering from subacute arthritis, probably gonorrheal in origin. He was also a chronic valvular cardiac patient. This was his second admission to Bellevue Hospital. When able, he had worked as a porter in a saloon, earning $2.00 per week. His relatives were in Europe. He had no savings. The prognosis was unfavorable.

CASE 23. A native of Italy. Age 28 years. A married man.

This patient landed at New York February 8, 1912. He was suffering from chronic pulmonary tuberculosis, which condition existed prior to landing. He was transferred to a chronic hospital. He had no savings and had a wife dependent on him. The prognosis was unfavorable.

CASE 24. A native of Ireland. Age 43 years. A single woman.

This patient landed at New York in 1913. Her medical history shows that she had delusions of persecution on board of ship and in her native country. She had been confined as insane in a hospital abroad. The diagnosis in this case was allied to manic depressive insanity, from causes existing prior to landing. The prognosis was unfavorable.

CASE 25. A native of Italy. Age 26 years. A married man.

This patient landed at New York May 29, 1911, and settled in Jersey City, N. J. On June 11, 1913, he came to this City to be admitted to the Hospital. After 3 or 4 weeks of treatment at the dispensary the medical history records a chancre, which he contracted 3½ years ago, prior to landing. The diagnosis on discharge was general systemic syphilis. This man was a laborer, earning $9.00 a week. From this sum he sent an allowance to his wife and mother in Europe. He had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 26. A native of Italy. Age 24 years. A married woman.

This patient landed at New York in September, 1910. Her family history showed that her mother died of chronic bronchitis and 2 sisters of tuberculosis. The patient was suffering from chronic pulmonary tuberculosis contracted prior to landing. She was transferred to a chronic hospital. Her husband earned but little and had 2 children dependent upon him. The prognosis was unfavorable.

CASE 27. A native of England. Age 18 years. A single man.

This patient landed at New York April 30, 1911. He was admitted to the Hospital to be treated for an abscess of the foot. His medical history showed that he had a like abscess 6 years ago. He also had pulmonary tuberculosis, existing prior to landing. He had no parents in the United States. He was employed as an iron worker and earned about $6.00 a week. The only relative he had in this City was a married sister. The prognosis was unfavorable.

CASE 28. A native of Germany. Age 31 years. A single man.

This patient landed at New York June 9, 1913, and took up his residence with his brother. After 3 days here he attempted to commit suicide by inhaling gas. His medical history was one of gas poisoning followed by convulsions. His diagnosis was also epilepsy. The prognosis was unfavorable.

CASE 29. A native of Hungary. Age 36 years. A married woman.

This patient landed at New York in June, 1912. Nine years prior to landing she contracted syphilis, for which she was treated for 3 weeks. Her diagnosis was systemic syphilis and emphysema. Her heart was also in poor condition. Prior to admission she had been ill 6 months. She had previously been a patient in Bellevue Hospital. Her husband, a porter, barely made a living. This patient died in the hospital on June 17, 1913.

CASE 30. A native of Turkey. Age 19 years. A single man.

This patient landed at New York December 15, 1912. His medical history shows that he had had a cough for 16 years. Prior to being admitted to Bellevue Hospital he was treated at a private hospital. His diagnosis was chronic pulmonary tuberculosis, which developed prior to landing. He had had hemorrhages for 10 weeks and had been unable to work. He had earned about $8.00 a week. He was all alone in this country and had no savings. He was transferred to a tuberculosis hospital. The prognosis was unfavorable.

CASE 31. A native of Italy. Age 27 years. A single woman.

This patient landed at New York October 8, 1912, and settled in New York State outside of the City, where she was employed as cook by a private family. She came to New York in June, 1913, and was admitted to the Hospital awaiting parturition. Her medical history indicates pregnancy prior to landing; otherwise her health was in good condition. She had no relative in this country. After recovery from childbirth this patient was discharged into the custody of officials of the United States Immigration Service.

CASE 32. A native of Austria. Age 62 years. A widow.

This patient landed at New York April 1, 1913. She was admitted to the psychopathic ward for observation. The diagnosis was senile dementia, prior to landing. This woman was an inmate of an institution in Europe, and was assisted in coming to the United States by her countrymen. She was transferred to a State hospital for the insane. Her case was taken up by the United States Immigration Service and a warrant for her deportation was said to have been issued.

CASE 33. A native of Italy. Age 37 years. A widow.

This patient landed at New York in November, 1906. Her family history shows that her husband had died of tuberculosis and that 2 of her children suffered from convulsions. The patient herself had suffered from epileptic seizures for 10 years. She was also a chronic cardiac. This woman had 4 children, 3 of whom were dependent upon her for support. One girl, 17 years old, worked in a factory. She had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 34. A native of Germany. Age 20 years. A single man.

This patient was a seaman, who deserted in 1911 and took a position as a baker in New York City, in violation of the rules and regulations of the United States Department of Labor. He was admitted to the Hospital to be treated for a fracture from a fall. He was unable to pay for his maintenance at the Hospital. The prognosis was favorable.

CASE 35. A native of Italy. Age 24 years. A married woman.

This patient landed at New York May 25, 1912. Her mother was a neurotic. She herself had always been nervous. She was admitted to the psychopathic ward for observation and transferred as insane to a State hospital. Her case was referred to the United States Immigration Service for deportation.

CASE 36. A native of Russia. Age 39 years. A married man.

This patient landed at New Orleans May 1, 1913. He was a deserted seaman, who landed and assumed another occupation, in violation of the rules and regulations of the United States Department of Labor. On June 13, 1913, he came to New York City, and 2 days thereafter was taken to the Hospital by ambulance. His medical history showed that he was a chronic alcoholic. The prognosis was unfavorable.

CASE 37. A native of Austria. Age 16 years. A girl.

This patient landed at Philadelphia in November, 1912. She came to New York June 7, 1913, and was admitted to the Hospital June 15th. Her medical history shows that she had always been anemic, never menstruated, and had pulmonary tuberculosis of 1 year's standing. She had been working as a dressmaker and earned about $6.00 a week. Her parents were in Austria. She had no relatives able to assist her. She had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 38. A native of Turkey. Age 19 years. A single man.

This patient was a seaman. He deserted in January, 1912, and settled in New York City and assumed another occupation, in violation of the rules and regulations of the United States Department of Labor. His medical history showed that he contracted syphilis in Europe. The diagnosis was acute secondary syphilis. The prognosis was unfavorable.

CASE 39. A native of Italy. Age 33 years. A widow.

This patient was admitted to the United States October 14, 1912, after two hearings before the Board of Special Inquiry held upon the ground that she might become a public charge. The diagnosis was syphilis of the nose and throat. Her medical history suggested a psychosis of paranoid type. She was mentally unstable prior to landing. She had 3 children living in Italy; 1 was 17 years of age, but 2 were dependent upon her for support. At the time of admission to the Hospital she had no savings. She was discharged at her own risk in an unimproved condition. The prognosis was unfavorable.

CASE 40. A native of Ireland. Age 21 years. A married man.

This patient was a seaman who had been sick in the ship's hospital 2 days prior to admission to Bellevue by ambulance. His condition was diagnosed as acute gonor-

rhea. This was contracted abroad. He was deported by the State Board of Charities.

CLASS I-2. Aliens Deportable Under the Federal Immigration Law.

CASE 1. A native of Turkey. Age 22 years. A married woman.

This patient landed at New York in July, 1911. She was suffering from chronic salpingitis, oöphoritis, and stenosis of cervix and uterus, with history prior to landing. She was dependent upon a husband earning $8.00 to $9.00 a week, and irregularly employed. They had no savings. The prognosis was unfavorable. In all probability she will be a chronic invalid.

CASE 2. A native of Germany. Age 28 years. A married man.

This patient landed at New York in February, 1913. He had been in New York City 2 weeks, previously in Connecticut. His wife, child, and parents lived in Germany. He was suffering from rheumatism, with history of 3 attacks of contributing gonorrheal infection in the years of 1906, 1908, and 1909. Prognosis for freedom from subsequent attacks unfavorable.

CASE 3. A native of Germany. Age 35 years. A married man.

This patient landed at New York in October, 1912. He was suffering from chronic otitis media, with history prior to landing. He had a wife and 4 young children in Germany, and was in debt. The prognosis for recovery was unfavorable and indicated a recurrent dependence.

CASE 4. A native of Australia. Age 20 years. A single man.

This patient landed at New York in April, 1913, and within 17 days was a patient in the Hospital. He was suffering from chronic cardiac valvular disease of 5 or 6 years existence. He had been unable to work for 2 years prior to landing. He was admitted to Bellevue twice in his 3 weeks stay in this country. The prognosis for recovery was unfavorable.

CASE 5. A native of Italy. Age 19 years. A single man.

This patient landed at New York in June, 1912. He was suffering from chronic cardiac valvular disease, with history prior to landing, complicated with malaria. The prognosis was unfavorable and indicated recurrent or chronic dependence.

CASE 6. A native of Italy. Age 24 years. A single woman.

This patient landed at New York in September, 1912. She had an illegitimate child 2½ years old in Italy. She was a patient in the Hospital for miscarriage. She also had pulmonary tuberculosis and a history of mental inferiority. The prognosis was unfavorable.

CASE 7. A native of Greece. Age 21 years. A single man.

This patient landed at New York in June, 1910. He was suffering from chronic venereal disease, also from inguinal hernia, with history of 6 years existence. He had earned $7.00 per week when employed. The prognosis was unfavorable.

CASE 8. A native of Russia. Age 33 years. A married man.

This patient landed at New York in December, 1910. He was suffering from multiple arthritis and chronic pleurisy. He had been in a hospital in Europe 6 years before with arthritis. He had a wife and 3 small children in Russia dependent upon him. The prognosis was unfavorable.

CASE 9. A native of Russia. Age 40 years. A married woman.

This patient landed at New York in July, 1910. She was in the Hospital for psychopathic observation, and was committed to a State hospital for insane. The history showed that the underlying conditions existed before landing in the United States. The prognosis was unfavorable.

CASE 10. A native of Ireland. Age 21 years. A single man.

This patient landed at New York April 29, 1913. He was admitted to the Hospital about 3 weeks afterward. He was a chronic cardiac and also had acute arthritis. His medical history showed that this attack of arthritis was a relapse. He was

an unskilled laborer. He had no relatives in this country and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 11. A native of Ireland. Age 23 years. A single woman.

This patient landed at New York February 19, 1910. Her medical history showed that she had been addicted to the use of alcohol and had had rheumatic fever 3 years prior to landing. She was treated at the time in a hospital in Europe. The diagnosis of her condition was chronic cardiac disease and chronic pericarditis. This woman had worked as a domestic. She had no savings at the time of admission to the Hospital. Her mother lived in Europe. Her sister, the only relative she had in this country, was unable to assist her. The prognosis was unfavorable.

CASE 12. A native of Jamaica. Age 20 years. A single man.

This patient was a seaman, discharged in New York City February 28, 1913. Three weeks afterward he was admitted to a public hospital, where he stayed 9 weeks. He was then admitted to Bellevue Hospital. His medical history showed that he had been suffering from chronic pulmonary emphysema and had had acute respiratory symptoms of 4 months existence. He was eventually deported to Jamaica by the State Board of Charities. The prognosis was unfavorable.

CASE 13. A native of Russia. Age 20 years. A single man.

This patient landed at New York in December, 1912. He had congenital malformation of the toe. He was discharged in an unimproved condition. He was a shoemaker and had been out of work for 2 months prior to admission to the Hospital. He lived with his parents, but they were unable to pay for his maintenance at the Hospital. The prognosis was unfavorable.

CASE 14. A native of Italy. Age 58 years. A married man.

This patient landed at Boston in May, 1913. He was admitted to the Hospital for psychopathic observation and was transferred as insane to a State hospital. His medical history recorded that he had been "mentally sick" in a hospital in Italy 9 years before. He had been an inmate of a New York State hospital and had been deported on a prior occasion.

CASE 15. A native of Mexico. Age 24 years. A married man.

This patient arrived in the United States in July, 1910. He had settled in New Jersey and had come to New York City 6 months prior to admission to the Hospital. His medical history indicated that he had been mentally unbalanced and had acted queerly for a long time, and that the causes underlying his condition existed prior to landing. He was deported at the expense of relatives in July, 1913.

CASE 16. A native of Russia. Age 19 years. A single woman.

This patient landed at New York July 3, 1912. She was admitted to the Hospital for psychopathic observation and transferred as insane to a State hospital. Her history indicated that the causes underlying her condition existed prior to landing.

CASE 17. A native of England. Age 33 years. A married man.

This patient was a seaman, discharged in New York May 23, 1913. On May 25, 1913, he was admitted to the Hospital to be treated for a laceration of the scalp and alcoholism. He had been addicted to alcohol prior to landing. He had a wife and 2 small children in England and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 18. A native of Hungary. Age 35 years. A single man.

This patient landed at New York in April, 1913. He went to a western state, and the day of his return to New York City, in May, 1913, he was admitted to the psychopathic ward for observation. He was transferred as insane to a State hospital. His diagnosis was general paresis. He was finally deported by the United States Immigration Service.

CASE 19. A native of Italy. Age 33 years. A married woman.

This patient on the way over to the United States had given birth to a child. She had been allowed to enter a hospital in the City by the immigration authorities. She was then brought by the ambulance of that hospital to Bellevue Hospital. Her husband, who accompanied her on the voyage, was detained at Ellis Island until she was able to travel. She did not pay for the medical treatment and maintenance re-

ceived at the Hospital. She was discharged in the custody of the United States Immigration Service and was permitted to land the following day.

CASE 20. A native of Austria. Age 43 years. A married man.

This patient landed at New York June 11, 1911. He was admitted to the Hospital suffering from chronic myocarditis, with a history of condition existing prior to landing. The general condition of his health was too poor for him to be able to do any work. He had no savings at the time of admission to the Hospital, as he had been out of work since January, 1913. He had been a patient at Bellevue previously. His wife and 4 children, living in Austria, were dependent upon him for support. He had no relatives in this country. The prognosis was unfavorable.

CASE 21. A native of Austria. Age 19 years. A single woman.

This patient landed at New York April 29, 1913. On May 26, 1913, she was taken to the Hospital for psychopathic observation. She had an insane sister. Her history showed underlying prior causes. She was deported by the United States Immigration Service.

CASE 22. A native of Russia. Age 25 years. A single woman.

This patient landed at New York August 27, 1912. She was admitted to the psychopathic ward for observation and transferred as insane to a State hospital. Her history indicated underlying prior causes. She was deported by the United States Immigration Service.

CASE 23. A native of Germany. Age 25 years. A single woman.

This patient landed at New York in December, 1910. She was admitted for psychopathic observation and transferred as insane to a State hospital. Her history showed that she had been in an asylum in Europe. She was deported by the United States Immigration Service.

CASE 24. A native of Switzerland. Age 22 years. A single man.

This patient landed at New York October 14, 1910. He was admitted to the Hospital to be treated for chronic alcoholism. He was transferred to the psychopathic ward for observation and later was sent as insane to a State hospital. He had no relatives in this country. The prognosis was unfavorable.

CASE 25. A native of Italy. Age 24 years. A single man.

This patient landed at New York for the second time October 25, 1912. His medical history showed that he had been under psychopathic observation at Bellevue 6 years before during a previous stay in this country, at which time he was transferred as insane to a State hospital. He was again transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 26. A native of Greece. Age 35 years. A married woman.

This patient and her husband landed at New York in April, 1913. She was first admitted to a private hospital and from there transferred to Bellevue Hospital. She was suffering from hysteria, due to pregnancy, of 3 months existence. Her husband was unemployed at the time and could not pay for the medical treatment and maintenance at the Hospital. She was readmitted to Bellevue within 3 days after discharge.

CASE 27. A native of Ireland. Age 25 years. A single man.

This patient landed at New York May 13, 1911. The medical record showed that he had been an alcoholic for 4 or 5 years. The diagnosis was chronic alcoholism and acute gastritis. He had no relatives in this country and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 28. A native of Austria. Age 18 years. A single woman.

This patient landed at New York April 22, 1913. Her medical history showed that she had multiple septic arthritis, from which she had been suffering prior to landing. She was alone in this country and had no savings. She was discharged in the custody of an immigrants' society. The prognosis was unfavorable.

CASE 29. A native of Russia. Age 20 years. A single woman.

This patient landed at New York in 1913. She was admitted to the Hospital for psychopathic observation. Her medical history showed her condition existed prior

to landing, and that there was insanity in the family. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 30. A native of Germany. Age unknown. A single man.

This patient landed at New York in 1912. He was arrested for assault and referred to the psychopathic ward for observation. The diagnosis was insanity with criminal tendencies, with a history of condition existing prior to landing. The prognosis was unfavorable.

CASE 31. A native of Finland. Age 26 years. A single man.

This patient was a discharged seaman. He came to New York City last in April, 1913, and assumed occupation in the employ of an electrical company. He had malaria, contracted 7 months prior to his admission. He had no relatives in the United States and his mother in Finland was dependent upon him. He had no savings at the time of admission to the Hospital. The prognosis was unfavorable, as the patient would probably need further hospital treatment.

CASE 32. A native of Spain. Age 22 years. A single man.

This patient landed at New York December 16, 1911. He was admitted to the Hospital to undergo an operation for hernia, which he had had since childhood. He had no relatives in this country and no savings at the time of admission to the Hospital. The prognosis was favorable.

CASE 33. A native of Hungary. Age 34 years. A married man.

This patient landed at New York in 1912. He was brought to the Hospital from outside the City for psychopathic observation. He was transferred as insane to a State hospital. His history showed that his condition originated prior to landing.

CASE 34. A native of Germany. Age 25 years. A married woman.

This patient landed at New York in 1911. The medical history showed that her mother had been peculiar and that the patient had had previous attacks of insanity. She was transferred as insane to a State hospital.

CASE 35. A native of Italy. Age 42 years. A single man.

This patient landed at New York May 31, 1913. His diagnosis was rheumatism, from which, his medical history showed, he had been suffering on board ship. Also, he had had gonorrhea previously. At the time of admission to the Hospital he had no savings. His cousin, the only relative he had in this City, was unable to help him financially. The prognosis indicated that this patient would in all probability require subsequent treatment.

CASE 36. A native of Austria. Age 29 years. A married man.

This patient landed at New York March 12, 1911. He had been suffering from a chronic urethral fistula, for which he had been operated upon in Europe. He was a waiter, unemployed for 10 weeks prior to admission to the Hospital. He had no savings with which to pay for medical treatment and maintenance. The prognosis was unfavorable.

CASE 37. A native of Germany. Age 27 years. A single woman.

This patient landed at New York in December, 1912. She was admitted to the psychopathic ward for observation. Her medical history showed that her mother was peculiar and that the patient had had mental peculiarities of many years standing. The prognosis was unfavorable.

CASE 38. A native of Russia. Age 35 years. A married woman.

This patient landed at New York in April, 1913. She was admitted to the Hospital for parturition. She was pregnant prior to landing. Her husband had been out of work for some time. There were 3 children in the family, all dependent upon the father for support, and they had no money at the time of his admission to the Hospital.

CASE 39. A native of Russia. Age 40 years. A married man.

This patient landed at New York March 18, 1912. His medical history showed that he had been suffering from rheumatism for 6 years. The diagnosis was chronic rheumatism and syphilis of the brain. He was transferred to a chronic hospital. He had been out of work for 6 months prior to admission. He had made only $3.00 a

week when employed and had no savings at the time of admission to the Hospital. He wished to be sent back to Russia. The prognosis was unfavorable.

CASE 40. A native of Germany. Age 28 years. A single man.

This patient was a seaman. He was taken to the Hospital to be treated for an injury which he sustained on board of ship prior to landing. The diagnosis was for suppurative condition of the right shoulder. He had no savings at the time of admission to the Hospital and could not pay for the treatment and maintenance he received there. The steamship company did not reimburse the Hospital. The prognosis for ultimate recovery was favorable. The patient was referred to the Department of Public Charities for further care.

CASE 41. A native of Austria. Age 53 years. A single woman.

This patient was admitted to the United States in 1910. She was in the Hospital for psychopathic observation and was transferred as insane to a State hospital. Her history showed that her condition originated before landing. The prognosis was unfavorable.

CASE 42. A native of Italy. Age 28 years. A single man.

This patient landed at New York in May, 1912. His medical history showed that he had had discharges from his ears for 6 years, and also had had frequent attacks of tonsilitis. The diagnosis was acute tonsilitis and chronic otitis media of both ears. He had no relatives in this country. He earned small wages when employed and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 43. A native of Austria. Age 25 years. A married man.

This patient landed at New York January 5, 1912. He was admitted to the Hospital suffering from rheumatism and organic heart disease, with history of condition existing prior to landing. He made only $10.00 per week, and had a wife and child dependent upon him for support. He had no savings and no relatives able to give him any aid. The prognosis was unfavorable.

CASE 44. A native of Russia. Age 32 years. A single man.

This patient landed at New York November 13, 1912. He was admitted to the Hospital for psychopathic observation. His medical history showed that his condition originated prior to landing with continuous symptoms since landing. His sister was an inmate of a State hospital for the insane. The patient was transferred as insane to a State hospital.

CASE 45. A native of Russia. Age 32 years. A married woman.

This patient landed at New York July 24, 1912. She had had an operation as a free patient in a private hospital in this City. The diagnosis was a malignant abdominal tumor, with history of development of such prior to landing. Her husband earned $10.00 per week and could not pay for her maintenance at the Hospital. There were 2 dependent children in the family. The prognosis was unfavorable.

CASE 46. A native of Italy. Age 39 years. A married woman.

This patient landed at New York November 24, 1912. In January, 1913, she was admitted to a private hospital, where she had an operation for carcinoma of cervix. In June, 1913, she was admitted to Bellevue Hospital. The diagnosis was inoperable cancer of uterus and of skin. Her history showed that this condition originated prior to landing. Her husband was an unskilled laborer without regular income. The prognosis was unfavorable.

CASE 47. A native of Turkey. Age 11 years. A boy.

This patient landed at New York in September, 1912. His medical history indicated backwardness of mental development, edema of face, and chronic valvular heart disease since early childhood. The father of this patient, a laborer, earned from $8.00 to $10.00 per week. There were 5 dependent children in the family. The prognosis was unfavorable.

CASE 48. A native of Greece. Age 37 years. A married man.

This patient landed at New York in 1910. He was admitted for psychopathic observation. The diagnosis was general paresis. The medical history showed that his condition originated prior to landing. This patient was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 49. A native of Ireland. Age 35 years. A single woman.

This patient landed at New York in April, 1912, but did not settle in this City. On June 10, 1913, she came from New Haven, Conn., and the next day was admitted to the Hospital. Her medical history showed constitutional psychopathic tendencies existing prior to landing. She was also an alcoholic. This woman had no savings at the time of admission to the Hospital. She had no relatives in this country, no permanent residence or settlement, and no regular income. The prognosis was unfavorable.

CASE 50. A native of Ireland. Age 25 years. A single man.

This patient landed at New York in July, 1912. He was a chronic alcoholic and admitted that he had been addicted to the use of alcohol since 16 years of age. He had no relatives in this country, no savings, and his work was irregular. The prognosis was unfavorable.

CASE 51. A native of Italy. Age 36 years. A single man.

This patient landed at New York in December, 1912. The diagnosis of his illness was bleeding hemorrhoids and severe secondary anemia, with cardiac involvement. His history showed that his condition existed prior to landing, with acute symptoms of 6 months existence. He was discharged in an unimproved condition at his own risk. He had no savings at the time of admission to the Hospital and no relatives able to assist him. The prognosis was unfavorable.

CASE 52. A native of Greece. Age 35 years. A married woman.

This patient and her husband landed at New York in April, 1913. She was first admitted to a private hospital and from there transferred to Bellevue Hospital. She was suffering from hysteria, due to pregnancy, of 3 months existence. Her husband was unemployed at the time and could not pay for the medical treatment and maintenance at the Hospital.

CASE 53. A native of Ireland. Age 27 years. A single man.

This patient landed at New York June 29, 1912. His medical history showed that he had had asthma since childhood. The diagnosis was asthma and suppurative area on chest, secondary to old wound by stabbing. This patient had earned very little and had no savings at the time of admission to the Hospital. His relatives were poor and unable to give him any assistance. The prognosis was unfavorable.

CASE 54. A native of Russia. Age 40 years. A married man.

This patient landed at New York in 1912. He was admitted to the Hospital for psychopathic observation and was transferred as insane to a State hospital. His history showed that this condition had originated prior to landing. The prognosis was unfavorable.

CASE 55. A native of Austria. Age 16 years. A boy.

This patient landed at New York in January, 1912. The diagnosis was acute rheumatic fever, myocarditis, and general arthritis. His history showed that this condition originated prior to landing. He had earned $16.00 a month in a factory. His father, a mill worker, could not pay for his maintenance and treatment at the Hospital. The prognosis was unfavorable.

CASE 56. A native of Cuba. Age 9 years. A boy.

This patient was admitted to the United States in March, 1913. In April, 1913, he came from San Francisco to this City. He had abscess of the brain. His history showed that this condition originated prior to landing. His father, a storekeeper, had an income of about $25.00 per month. There were 5 dependent children in the family. The prognosis was unfavorable.

CASE 57. A native of Russia. Age 34 years. A married man.

This patient landed at New York July 1, 1912. He was admitted to the Hospital for psychopathic observation. His medical history recorded mental peculiarities in childhood and insanity in Russia. He had been non-supporting since entry into this country. He was transferred as insane to a State hospital and referred to the United States Immigration Service for deportation. The prognosis was unfavorable.

CASE 58. A native of Italy. Age 30 years. A single man.

This patient landed at New York in April, 1911. The diagnosis was urethral stricture and chronic gonorrhea. His medical history recorded an attack of gonorrhea in Europe prior to landing, which was followed by a gradual obstruction in urethral flow. This man had no relatives here and had no savings. The prognosis was unfavorable.

CASE 59. A native of Russia. Age 28 years. A married man.

This patient landed at New York April 14, 1913. The diagnosis was pulmonary tuberculosis and general arthritis. This was his second admission to Bellevue Hospital. His history showed that his condition had originated prior to landing. He had been out of work since May, 1913. His brother, a laborer, could not help him in any way. The prognosis was unfavorable.

CASE 60. A native of Russia. Age 29 years. A single man.

This patient landed at New York in January, 1913. He was admitted to the psychopathic ward for observation. The medical records indicated that he had been constitutionally defective. He had been dependent on charity ever since landing in this country. The prognosis was unfavorable.

CASE 61. A native of Russia. Age 21 years. A single woman.

This patient landed at New York in January, 1911. Her condition was diagnosed as hysteria. Her history showed that she was mentally unstable prior to landing. This woman had been out of work for 2 weeks before admission to the Hospital. She had no savings and her sister, the only relative she had in this country, was unable to render her any material assistance. The prognosis was unfavorable.

CASE 62. A native of Italy. Age 19 years. A single man.

This patient landed at New York in December, 1912. He was admitted to the Hospital for psychopathic observation and transferred to a State hospital as insane. His history showed that his condition originated prior to landing. He was referred to the United States Immigration Service for deportation.

CASE 63. A native of Sweden. Age 40 years. A single woman.

This patient landed at New York October 1, 1911. The diagnosis was criminal abortion, perforated uterus, secondary pelvic sepsis. Her medical history showed that she had had another criminal abortion 3 years prior to admission to the Hospital. She had no relatives in this State. She had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CLASS I-3a. Aliens Deportable under the State Charities Law.—From causes existing prior to landing.

CASE 1. A native of Russia. Age 40 years. A married man.

This patient landed at New York in October, 1908. The diagnosis was chronic myocarditis and asthma, with history of condition existing prior to landing. He earned only $6.00 a week and had a wife and 5 small children in Europe. A daughter was working out at service in this country. The prognosis was unfavorable.

CASE 2. A native of Russia. Age 43 years. A married man.

This patient landed at New York in 1908. The diagnosis was syphilis, with a history of condition existing prior to landing. He also had tabes dorsalis, chronic pleurisy, and chronic splenitis. He had earned $18.00 a week when employed. His money was exhausted. His wife, and 5 children under 20 years of age, were in Russia. The prognosis was unfavorable.

CASE 3. A native of Germany. Age 62 years. A married man.

This patient landed at New York in 1891. The diagnosis was chronic alcoholism, with an alcoholic history for years prior to landing. His relatives were in Europe. The prognosis was unfavorable.

CASE 4. A native of Italy. Age 26 years. A single man.

This patient landed at New York in June, 1909. The diagnosis was tuberculosis of elbow joint, chronic cardiac disease, and pulmonary tuberculosis. Four years before, and prior to landing, he sustained an injury to his elbow. He had been working

as a hotel helper and earned very little. He had been out of work for some time before admission to the Hospital and had no savings. A sister, a laundress, earned $5.00 a week and could give him little assistance. The prognosis was unfavorable.

CASE 5. A native of Ireland. Age 29 years. A married man.

This patient landed at New York in September, 1908. The diagnosis was chronic alcoholism. The history of this patient showed that he had been a chronic alcoholic for 6 years. When employed he earned $16.00 a week. He had a wife dependent upon him. He had no savings and did not pay for the medical treatment and maintenance received at the Hospital. The prognosis was unfavorable.

CASE 6. A native of Ireland. Age 43 years. A single man.

This patient landed at New York July 13, 1897. The diagnosis was chronic alcoholism, with an alcoholic history prior to landing. He had been a public charge many years before because of alcoholism. This man had no savings at the time of admission to the Hospital and could not pay for the medical treatment and maintenance received therein. The prognosis was unfavorable.

CASE 7. A native of Ireland. Age 35 years. A single man.

This patient landed at New York in July, 1900. The diagnosis was chronic alcoholism, with an alcoholic history prior to landing. He had no savings and no relatives in this country. The prognosis was unfavorable.

CASE 8. A native of Ireland. Age 25 years.

This patient landed at Boston, Mass.; in April, 1907. In March, 1913, he came from Boston to this City. He was admitted to the Hospital to be treated for acute gastritis following alcoholic poisoning. This man was a chronic alcoholic, with an alcoholic history prior to landing. He had no relatives in this City and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 9. A native of Germany. Age 29 years. A single man.

This patient landed at New York September 26, 1900. He was admitted to the Hospital to be treated for acute gastritis following alcoholic poisoning. He was a chronic alcoholic, with an alcoholic history prior to landing. He had no savings at the time of admission to the Hospital and no relatives in this country. The prognosis was unfavorable.

CASE 10. A native of Ireland. Age 24 years. A single man.

This patient landed at New York in April, 1909. He was admitted to the Hospital to be treated for a fracture of fibula, which he received while in an intoxicated condition. The diagnosis was delirium tremens and fracture of leg. His medical history showed that he had been a chronic alcoholic, with an alcoholic history prior to landing. This man was an unskilled laborer. His work was irregular and he had no savings. The prognosis was unfavorable.

CASE 11. A native of Norway. Age 49 years. A single man.

This patient landed at New York in 1901. The diagnosis was chronic arthritis and chronic valvular cardiac disease. His medical history showed a record of repeated attacks of rheumatism since the age of 16, and valvular cardiac disease prior to landing. He had been out of work for some time and had no savings at the time of admission to the Hospital, and no relatives in this part of the country. The prognosis was unfavorable.

CASE 12. A native of Ireland. Age 35 years. A single man.

This patient landed at New York in October, 1904. His diagnosis was chronic alcoholism, existing prior to landing. He was an unskilled laborer. He had no savings and no regular income. The prognosis was unfavorable.

CASE 13. A native of Germany. Age 28 years. A single man.

This patient landed at New York in 1904. The diagnosis was alcoholic poisoning and toxic psychosis. His medical history showed chronic alcoholism prior to landing. This man had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 14. A native of Roumania. Age 22 years. A single woman.

This patient landed at New York August 5, 1907. She had an exophthalmic goiter of 6 years existence, originating prior to landing. Her condition was such as would probably make her an invalid for life. She lived with her parents. Her father had no occupation, and the family subsisted upon the earnings of 2 of the older children, who earned $8.00 and $12.00, respectively. They were unable to pay for the medical treatment and maintenance the patient received at the Hospital. The prognosis was unfavorable.

CASE 15. A native of Italy. Age 35 years. A married man.

This patient landed at New York in 1906. He was admitted to the Hospital to be treated for a fistula of the urethra, with a history of condition existing prior to landing. He also had syphilis. He was discharged in an unimproved condition, undoubtedly in need of further medical treatment. He had no savings and no relatives in this country. His wife lived in Italy and depended upon him for support. The prognosis was unfavorable.

CASE 16. A native of Austria. Age 55 years. A married man.

This patient came to New York in March, 1909, as a second-class passenger. The diagnosis of his condition was calculus of right kidney, chronic sciatic rheumatism, asthma, and chronic valvular cardiac disease, with history of conditions existing prior to landing. He was a peddler and his income was uncertain. Because of illness he had not done anything for 2 months prior to admission to the Hospital. His wife, 50 years old, and 1 child were dependent upon him for support. He had 2 daughters working as domestics, whose whereabouts were unknown. The prognosis was unfavorable.

CASE 17. A native of Ireland. Age 46 years. A single man.

This patient landed at New York April 23, 1909. The diagnosis was chronic alcoholism, which existed prior to landing. This man had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 18. A native of Italy. Age 40 years. A single woman.

This patient landed at New York in 1907. The diagnosis was subacute septicæmia and chronic cardiac disease. Her medical history showed that she had been a chronic cardiac prior to landing. Three years before entering the Hospital the patient had a miscarriage, though unmarried. This woman was alone in the United States, earned only $6.00 per week when employed, and had no savings at the time of admission to the Hospital. The prognosis for recovery was unfavorable.

CASE 19. A native of Germany. Age 36 years. A single man.

This patient landed at New York in August, 1903. He was a chronic alcoholic, addicted to the use of alcohol since the age of 18, and a "repeater" at Bellevue. He had been out of work for 3 weeks and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 20. A native of Ireland. Age 27 years. A married man.

This patient landed at New York August 29, 1907. He had been admitted to the Hospital to be operated upon for an abscess about the rectum. After the operation he developed delirium tremens. His medical history showed that he had been a drinking man for many years, and prior to landing. He had earned $12.00 a week as a blacksmith. His wife and a 5-year-old child were dependent upon him for support. At the time of entering the Hospital he had no savings and could not pay for the medical treatment and maintenance therein. The prognosis was unfavorable.

CASE 21. A native of Ireland. Age 41 years. A single man.

This patient landed at New York in January, 1900. The diagnosis was alcoholic poisoning. His medical history showed that he had chronic alcoholism and constitutional psychopathic tendencies existing prior to landing. This was at least his fourth admission to Bellevue Hospital. He was employed irregularly as a hospital helper. He had been out of work for 1 month before entering the Hospital. He had no savings and no relatives willing to pay for his maintenance at the Hospital. The prognosis was unfavorable.

CASE 22. A native of Austria. Age 28 years. A single man.

This patient landed in the United States in 1904, and came to this City from Pennsylvania a day before admission to the Hospital. He was a chronic alcoholic, and his medical history indicated that he had been addicted to the use of alcohol prior to landing. He was a "repeater" at Bellevue. He had been out of work for some time and had no money at the time of admission to the Hospital. He had no relatives in this country. The prognosis was unfavorable.

CASE 23. A native of Italy. Age 38 years. A married woman.

This patient landed at New York in August, 1909. Her medical history showed that she had been an invalid prior to landing from uterine trouble, resulting in carcinoma of the cervix. This woman was discharged in an unimproved condition. Her husband was unable to pay for the medical treatment and maintenance she received at the Hospital. The patient will undoubtedly need further care. The prognosis was unfavorable.

CASE 24. A native of Hungary. Age 17 years. A single woman.

This patient landed at New York in December, 1909. The diagnosis was hysteria and constitutional mental inferiority. Her condition must have originated prior to landing. This was at least the third instance of the patient's dependence upon the City. The prognosis was unfavorable.

CASE 25. A native of Ireland. Age 47 years. A single man.

This patient landed at New York in January, 1904. He had been suffering from chronic myocarditis. His condition originated prior to landing. He had been out of work a whole year. He had no savings and no relatives in this country. The prognosis was unfavorable.

CASE 26. A native of England. Age 39 years. A single man.

This patient landed at New York in March, 1907, as a second-class passenger. The diagnosis was of recurrent arthritis of hips. His medical history recorded rheumatism 28 years ago and 6 subsequent outbreaks of syphilis. This was at least his second admission to Bellevue Hospital. He had been employed irregularly, and had no savings at the time of admission and no relatives in this country. The prognosis was unfavorable.

CASE 27. A native of Ireland. Age 32 years. A single man.

This patient landed at New York June 11, 1908. The diagnosis was chronic alcoholism. His medical history showed that he had been addicted to the use of alcohol since the age of 22. This was at least his second admission to Bellevue. He had no definite occupation. He was employed irregularly and had no savings at the time of admission to the Hospital. His father was living in Ireland. The prognosis was unfavorable.

CASE 28. A native of Germany. Age 40 years. A single man.

This patient landed at New York in 1899. The diagnosis was alcoholic poisoning. He had been a chronic alcoholic prior to landing. He had previously been a dependent in this City. He had no savings and earned only $6.00 per week when employed. His parents were in Germany. The prognosis was unfavorable.

CASE 29. A native of Russia. Age 29 years. A married man.

This patient landed at New York in 1907. His diagnosis was chronic arthritis and deformity of hip. An aggravated condition of an old injury to his hip necessitated a second operation. He had received this injury in 1903, 4 years prior to landing. He had been out of work for 2 months before entering the Hospital. His wife and 5 small children were dependent upon him for support. His income was uncertain and he had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 30. A native of Ireland. Age 32 years. A single man.

This patient landed at New York in May, 1906. The diagnosis was chronic alcoholism and chronic cardiac disease, originating prior to landing. Also, he had had syphilis for 5 years prior to admission to the Hospital. He was an unskilled laborer and employed irregularly. He had been out of work for 3 weeks before entering the Hospital and had no savings at the time of admission to the Hospital, and no relatives in this State. The prognosis was unfavorable.

CLASS I-3b. Aliens Deportable under the State Charities Law.—From causes whose priority to landing is not certain.

CASE 1. A native of Greece. Age 21 years. A single man.

This patient landed at New York in May, 1912. The diagnosis was chronic pulmonary tuberculosis. The probability is that this patient had this ailment prior to landing in the United States. His relatives all lived in Europe. He was a bootblack, but had been unemployed for some time. The prognosis was unfavorable.

CASE 2. A native of Austria. Age 27 years. A married woman.

This patient landed at New York in September, 1910. The diagnosis was chronic pelvic trouble, which probably originated prior to landing. Her condition was so serious that she died in the Hospital 3 weeks after admission. The patient and 1 child had been dependent on her husband, who earned $13 a week. She had had an operation previously.

CASE 3. A native of Russia. Age 32 years. A single man.

This patient landed at New York in 1908. He had chronic pulmonary tuberculosis. He had been ill 3 years and had had previous hospital treatment in this City. His trouble may have originated prior to landing. His parents are still living in Europe. The prognosis was unfavorable for recovery and indicated chronic or recurrent dependence.

CASE 4. A native of Scotland. Age 39 years. A married man.

This patient landed at New York in September, 1908. He came to New York City from New Jersey 2 weeks before admission to the Hospital. The diagnosis was chronic alcoholism, with 4½ years history of alcoholism admitted. His family lived in Scotland. The prognosis was unfavorable for cure and indicated recurrent or chronic dependence.

CASE 5. A native of Austria. Age unknown. A single man.

This patient landed at New York in 1903. The diagnosis was chronic cardiac valvular disease, with complication of rheumatic fever. The history indicated that he probably had these conditions prior to landing in the United States. The patient earned $15.00 a week when employed, but had been out of work 7 months. His nearest relative in this country was a cousin. The prognosis was unfavorable.

CASE 6. A native of Hungary. Age 33 years. A married man.

This patient landed at New York in June, 1912. The diagnosis was cancer of the stomach. The medical history showed that he had had a gastric ulcer prior to landing in the United States. He had earned $9 a week when employed. The prognosis was unfavorable.

CASE 7. A native of Italy. Age 20 years. A single man.

This patient landed in the United States in May, 1912, and came to this City from New Jersey in April, 1913. The diagnosis was chronic pulmonary tuberculosis, with acute symptoms of 4 months existence. It could not be determined whether his illness was due to causes existing prior to landing. He was alone in this country. He had been out of work 2 months and had no savings at the time of admission to the Hospital. The prognosis was unfavorable and indicated recurrent or chronic dependence.

CASE 8. A native of Italy. Age 28 years. A married man.

This patient landed at New York in October, 1912. The diagnosis was suppurative pleurisy, which was probably due to a tuberculous condition prior to landing. He was unemployed for 2 months before entering the Hospital and had no savings. He had no relatives in this country. The prognosis for cure was unfavorable.

CASE 9. A native of Russia. Age 34 years. A married man.

This patient landed at New York in 1909. The diagnosis was cerebro-spinal syphilis. He had a chronic stomach trouble of 14 years existence. After 5 days in the Hospital he was discharged home in an unimproved condition. It could not be determined whether the patient had been afflicted with the same disease prior to landing. The prognosis was unfavorable and indicated recurrent or chronic dependence.

CASE 10. A native of Roumania. Age 38 years. A single man.

This patient landed at New York in 1907. The diagnosis was cirrhosis of the liver and cardiac trouble. It was uncertain whether his condition originated prior to landing. The patient's general physical condition was poor. He was transferred to a chronic hospital. He had been unemployed 6 months and had no savings. The prognosis was unfavorable. The patient seemed sure to need subsequent treatment.

CASE 11. A native of Ireland. Age 35 years. A single man.

This patient landed at New York June 20, 1905. The diagnosis was chronic cardiac valvular disease and acute rheumatic fever. It could not be determined whether his condition originated prior to landing. He had been out of work for over a month. He had earned only $25 a month when employed and had no savings. The prognosis for cure was unfavorable. The patient seemed likely to have recurrent attacks.

CASE 12. A native of Spain. Age 27 years. A single man.

This patient landed at New York July 17, 1912. The diagnosis was secondary syphilis. His medical history had a record of gonorrhea 5 years before. It was not determined whether the patient had contracted syphilis prior to landing. He had no savings at the time of admission to the Hospital. His brother earned only $6 a week and was unable to help him. His condition indicated subsequent need for hospital treatment. The prognosis was unfavorable.

CASE 13. A native of Italy. Age 18 years. A single man.

This patient landed in the United States June 4, 1912, and came to New York City from Pennsylvania in March, 1913. It seemed probable that his trouble would deform him. His medical history showed that he had empyema in August, 1912, and that since then his health had been in a bad condition. The diagnosis was old empyema with fistula. This patient had been treated 8 months in a hospital in Pennsylvania. He had no relatives in this country. Since his arrival in this country he had been almost continuously a public charge. It was strongly probable that his condition originated prior to landing. The prognosis was unfavorable.

CASE 14. A native of Ireland. Age 32 years. A single man.

This patient landed at New York February 20, 1906. The diagnosis was chronic alcoholism. It could not be determined whether he had been a chronic alcoholic prior to landing. He had been out of work 5 weeks at admission and, though he claimed to have money in the bank, he failed to pay for his treatment and maintenance in the Hospital. The prognosis for cure of alcoholism was unfavorable.

CASE 15. A native of Germany. Age 39 years. A widow.

This patient landed at New York in 1900. The diagnosis was chronic cardiac valvular disease. It could not be determined whether this condition existed prior to landing. She earned $25 a month as a domestic and supported a daughter 7 years of age. She had no other relatives in this country and no savings. The prognosis was unfavorable and indicated recurrent dependence.

CASE 16. A native of the West Indies. Age 21 years. A single man.

This patient landed at New York January 22, 1913. The diagnosis was pulmonary tuberculosis and acute pneumatic fever, with cardiac complications. He was of an inherently poor constitution and seemed likely to return to the Hospital for further treatment. He had no savings at the time of admission and had no relatives in this country. The prognosis was unfavorable. He was discharged from the Hospital after 8 days stay and readmitted 3 days later with the same diagnosis.

CASE 17. A native of Russia. Age 15 years. A girl.

This patient landed at New York in 1910. The diagnosis was cerebro-spinal meningitis. It could not be determined whether her condition was due to causes existing prior to landing. Her parents were living in Russia. She had an aunt in Chicago, but had no relatives in this City. She had been working in a shirtwaist factory and earning $5.00 per week. The prognosis was unfavorable.

CASE 18. A native of Russia. Age 32 years. A single man.

This patient landed at Boston in August, 1907. He came to New York on his way to Europe and was admitted to the Hospital on the day of arrival here. The diagnosis

was chronic pulmonary tuberculosis and chronic pleurisy. One of his brothers had died of tuberculosis. It could not be determined whether his condition existed prior to landing. He had money for passage to Europe, but could not pay for the medical treatment and maintenance he received at the Hospital. The prognosis was unfavorable.

CASE 19. A native of Ireland. Age 23 years. A single man.

This patient landed at New York in May, 1907. The diagnosis was chronic pulmonary tuberculosis and alcoholism. The condition probably originated prior to landing. He had been out of employment since November, 1912. His parents lived in Ireland. The prognosis was unfavorable, and indicated chronic dependence.

CASE 20. A native of Spain. Age 29 years. A single man.

This patient was a seaman who came to New York in 1912. The diagnosis was cerebro-spinal syphilis. His condition probably existed prior to landing. This was at least his second admission to Bellevue. He had been out of work a number of weeks before entering the Hospital and had no savings. The prognosis was unfavorable and indicated recurrent or chronic dependence.

CASE 21. A native of Russia. Age 33 years. A married woman.

The patient landed in the United States in May, 1904, and came to this City from New Jersey 4 weeks before admission. The diagnosis was chronic valvular disease, existing for 7 years preceding admission. The medical history showed that at the age of 17 she had an attack of fever lasting 5 weeks. The cardiac condition may have existed since then, and certainly existed long prior to coming to this State. This woman had been treated in the general hospital in New Jersey for a period of 6 weeks. Her husband, a weaver, had been unemployed 3 months and had no savings. There were 4 dependent children in the family. The prognosis was unfavorable and indicated chronic dependence.

CASE 22. A native of Ireland. Age 60 years. A widower.

This patient landed in the United States in September, 1881, and came to this City from Florida May 24, 1913, 6 days before admission. The diagnosis was chronic alcoholism, with a record of alcoholism for many years, probably existing prior to landing, and certainly prior to coming to this State. He had previously been a patient in Bellevue. He had been out of work 5 weeks and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 23. A native of Russia. Age 19 years. A single man.

The patient landed at New York in 1910. The diagnosis was chronic pulmonary tuberculosis. It could not be determined whether his condition existed prior to landing. He had been out of work for some time. His parents were living in Russia, and his sister, the only relative he had in this country, was unable to help him. The prognosis was unfavorable and indicated recurrent dependence.

CASE 24. A native of Roumania. Age 58 years. A married man.

This patient landed at New York in 1903. The diagnosis was emphysema, bronchitis, and myocarditis. His medical history showed that his heart had exhibited acute symptoms of poor condition for at least 3 years. It could not be determined that his condition existed prior to landing. This man's earnings were very small. He had a wife to support, and had no savings at the time of admission to the Hospital. He had no near relatives. The prognosis was unfavorable and indicated recurrent and finally chronic dependence.

CASE 25. A native of Germany. Age 54 years. A single man.

This patient landed at New York in 1887. The diagnosis was chronic alcoholism, with history of heavy drinking for many years. This man had been unemployed 9 weeks and had no savings. He was transferred to a chronic hospital. The prognosis for cure was unfavorable and indicated recurrent dependence.

CASE 26. A native of Ireland. Age 33 years. A single man.

This patient landed at New York in November, 1911, and came to this City from New Jersey in December, 1913. The diagnosis was alcoholic poisoning. His medical history showed addiction to the use of alcohol since arrival in this country. He had no relatives in the United States. He had been out of work 3 weeks and had no savings. The prognosis for cure was unfavorable.

CASE 27. A native of British West Indies. Age 22 years. A single man.

This patient landed at New York in 1906. The diagnosis was of a venereal condition, which had previously been treated at Bellevue Hospital. His medical history did not show that the condition originated prior to landing. The patient had been out of work 5 months and had no savings. His parents were living in the West Indies, and his sister, the only relative in this country, could give him no assistance. The prognosis for cure was unfavorable.

CASE 28. A native of Austria. Age 43 years. A single man.

This patient landed at New York in 1904. The diagnosis was chronic pulmonary tuberculosis. He was transferred to a chronic hospital in an unimproved condition. The history did not show that this trouble originated prior to coming to this country. He had been in the City and State only 6 months and had been acutely ill before then. He had been out of work 8 months and had no savings. His brother, living in this City, was unable to help him. The prognosis for cure was unfavorable and indicated chronic dependence.

CASE 29. A native of Russia. Age 28 years. A single woman.

This patient landed at New York in 1904. The diagnosis was chronic pulmonary tuberculosis and tuberculous glands of neck. Her physical condition was very poor. It could not be determined that her condition originated prior to landing. When working she had earned $6.00 per week, but she had been out of work for some time and had no savings at the time of admission to the Hospital. Her brother and sister, living in this country, were not in a position to give her any material assistance. Her father lived in Russia. The prognosis was unfavorable.

CASE 30. A native of Venezuela. Age 28 years. A single man.

This patient was a seaman, discharged at New York in October, 1912. The diagnosis was gonorrhea. It could not be determined whether this was contracted prior or subsequent to landing. This man had no savings and had no relatives in this country. The prognosis was unfavorable and indicated recurrent dependence.

CASE 31. A native of Ireland. Age 44 years. A single woman.

This patient landed at New York in June, 1894. The diagnosis was chronic alcoholism, with an alcoholic history for at least 18 years. This was at least her third admission to the alcoholic ward in Bellevue. She had also been treated for alcoholism in another public hospital. Her sister, also an habitual alcoholic, had been treated at Bellevue. This woman had been unemployed for 2 months prior to admission to the Hospital. The prognosis was unfavorable and indicated recurrent dependence.

CASE 32. A native of Ireland. Age 40 years. A single man.

This patient landed at New York in April, 1899. The diagnosis was chronic pulmonary tuberculosis. His medical history showed that he had had a cough for 25 years. The general condition of this man's health was very poor. He had no relatives in this country and had no savings at the time of admission to the Hospital. His parents lived in Ireland. He was transferred to a tuberculosis hospital. The prognosis was unfavorable and indicated chronic invalidism.

CASE 33. A native of Germany. Age 40 years. A single man.

This patient landed at New York in May, 1903. The diagnosis was chronic cardiac valvular disease and chronic alcoholism. In 1911 he had been a patient for cardiac disease at a public hospital for 2 months. He was without funds and had no relatives in this country. The prognosis was unfavorable.

CASE 34. A native of Russia. Age 38 years. A married man.

This patient landed at Boston in 1907. He was admitted to the Hospital to be operated upon for inguinal hernia. He also had advanced pulmonary tuberculosis, with acute attacks during 2 years. He had been out of work 2 years and was supported by his wife. The prognosis was unfavorable and indicated chronic dependence.

CASE 35. A native of Ireland. Age 49 years. A single man.

This patient landed at New York in 1883. The diagnosis was chronic alcoholism. This was at least his fifth admission to the alcoholic ward in Bellevue. The medical history showed addiction to the use of alcohol ever since arrival in this country. He had no relatives here and had no savings at the time of admission to the Hospital. The prognosis was unfavorable and indicated subsequent returns to a hospital.

CASE 36. A native of Greece. Age 21 years. A single man.

This patient landed at New York August 10, 1911. The diagnosis was chronic gonorrhea and sciatica. He had been out of work for some time and had no savings. His parents were living in Greece and he had no relatives in this country. The prognosis was unfavorable and indicated that the patient would need further hospital treatment.

CASE 37. A native of Syria. Age 32 years. A married woman.

This patient landed at New York in July, 1909. The diagnosis was chronic nephritis. It could not be determined whether the condition existed prior to landing. She was also a chronic cardiac. This woman and her husband kept furnished rooms, but were unable to meet their expenses and had no savings. They had 1 child at school. The prognosis was unfavorable and indicated recurrent dependence.

CASE 38. A native of Ireland. Age 40 years. A widow.

This patient landed at New York in November, 1906. The diagnosis was chronic alcoholism. This was at least her seventh admission to the alcoholic ward at Bellevue. She had 2 children under 14 years of age who were maintained in an institution in Ireland. She had no relatives in this country. She had been out of work for some time and had no savings. The prognosis was unfavorable.

CASE 39. A native of Austria. Age 18 years. A single woman.

This patient landed at New York in 1911. The diagnosis was exophthalmic goitre. Her general condition was very poor. It could not be determined whether patient's condition was due to causes existing prior to landing. She had no relative in this country. She earned very little when employed and had no savings. The prognosis was unfavorable and indicated subsequent returns to a hospital.

CASE 40. A native of Ireland. Age 25 years. A single woman.

This patient landed at New York September 11, 1910. She had been in New York State and City only 5 weeks prior to this admission. She was admitted to the Hospital to be treated for after effects of parturition. The diagnosis was chronic gonorrhea and involution of uterus. This patient had been confined in another municipal hospital and afterward treated in still another before admission to Bellevue. She had 2 brothers in this country, 1 living in Philadelphia and another in New Jersey. She was removed by the State Board of Charities to Philadelphia, Pa. The prognosis was unfavorable.

CASE 41. A native of Germany. Age 33 years. A single man.

This patient landed at New York in 1899. The diagnosis was chronic pulmonary tuberculosis, chronic alcoholism, and multiple neuritis. Two years before he had been in a municipal hospital for tuberculosis. This was at least his second admission to Bellevue. He was alone in this country and had no savings. His parents were living in Germany. The prognosis was unfavorable.

CASE 42. A native of Ireland. Age 22 years. A single woman.

This patient landed at New York in October, 1910. The diagnosis was chronic pulmonary tuberculosis. It could not be determined whether her condition had originated prior to landing. She was transferred to a tuberculosis hospital. She had a sister and brother in this country, but her parents were living in Ireland. The prognosis was unfavorable and indicated chronic dependence.

CASE 43. A native of England. Age 30 years. A single man.

This patient landed at New York in 1903. He came to this City from Albany, where he had settled on the day of admission to the Hospital. The diagnosis was chronic alcoholism and fracture of skull. He had been unemployed 5 weeks and had no savings. He had no relatives in this country. The prognosis for alcoholism was unfavorable.

CASE 44. A native of Italy. Age 42 years. A single man.

This patient landed at New York August 9, 1909. The diagnosis was syphilis. The patient was discharged in an unimproved condition at his own risk. He had no relatives in the United States and had no savings at the time of admission to the Hospital. The prognosis was unfavorable and indicated recurrent dependence.

CASE 45. A native of Turkey. Age 33 years. A married man.

This patient landed at New York in June, 1911. The diagnosis was secondary syphilis, apparently contracted subsequent to landing. This man had a wife and 2 children in Turkey dependent upon him for support. He had no relatives here and at the time of admission to the Hospital had no savings. The prognosis was unfavorable and indicated recurrent dependence.

CASE 46. A native of Russia. Age 29 years. A single man.

This patient landed at New York in 1903. The diagnosis was tuberculous arthritis, of 12 months existence. His medical history showed that he had had an attack of gonorrhea 4 years before. He had no relatives in the United States and had no savings at the time of admission to the Hospital. The prognosis was unfavorable and indicated recurrent dependence.

CASE 47. A native of Norway. Age 60 years. A single woman.

This patient landed at New York in 1905. The diagnosis was varicose ulcer, with previous history of varicose veins. The prognosis was unfavorable and indicated chronic dependence.

CASE 48. A native of Austria. Age 20 years. A single woman.

This patient landed at New York in 1913. She was admitted to the Hospital for a fracture of the hip and for psychopathic observation. She was, however, transferred to a chronic hospital for further treatment. The prognosis was unfavorable and indicated chronic dependence.

CASE 49. A native of Ireland. Age 23 years. A single man.

This patient landed at New York in May, 1907. The diagnosis was chronic pulmonary tuberculosis and chronic alcoholism. This was his second admission to Bellevue. The condition probably originated prior to landing. He had been out of work since November, 1912. His parents lived in Ireland. He was transferred to a tuberculosis hospital for further treatment. The prognosis was unfavorable and indicated chronic dependence.

CASE 50. A native of Austria. Age 39 years. A married man.

This patient landed at New York March 18, 1911. The diagnosis was pulmonary tuberculosis, with an illness of 8 weeks before admission. This man had been out of work 8 weeks because of illness and had no savings. He had a wife and 3 children dependent upon him for support. The prognosis was unfavorable and indicated recurrent and finally chronic dependence.

CLASS I-3c. Aliens Deportable under the State Charities Law.—From causes existing subsequent to landing.

CASE 1. A native of Hungary. Age 19 years. A married woman.

This patient landed at New York in December, 1909. The diagnosis was chronic pulmonary tuberculosis, with 9 months' acute illness. She had numerous cavities in both lungs. She had come to the City from New Jersey 7 months before admission to the Hospital. It could not be determined whether the condition originated prior to landing, but it existed prior to coming to New York State. She was dependent upon her husband, who earned $10.00 a week. The prognosis was unfavorable.

CASE 2. A native of Ireland. Age 28 years. A single man.

This patient landed at New York in July, 1903. He had been in New York 15 months and previously was in Philadelphia. The diagnosis was gonorrheal arthritis, affecting a number of joints. He had previously been admitted to the Hospital and had a history of gonorrheal infection for the last 3½ years. His condition existed prior to his coming to New York State. The prognosis was unfavorable.

CASE 3. A native of South America. Age 22 years. A single man.

This patient landed at New York in 1908. The diagnosis was gonorrheal infection, with acute arthritis. This patient had earned $8.00 a week when employed. The prognosis was unfavorable.

CASE 4. A native of Italy. Age 37 years. A widower.

This patient landed at New York in December, 1909. The diagnosis was malaria, with history of a previous attack. His parents lived in Europe. He had earned $4.00 a week when employed, but he had been unemployed for 2 months prior to admission. The prognosis indicated possible recurrent dependence.

CASE 5. A native of Spain. Age 41 years. A married man.

This patient landed at New York in July, 1905. The diagnosis was hysteria. He had a history of several attempts at suicide, and was in delirium when admitted to the Hospital. He had earned $40.00 a month when working. His wife and 2 small children were in Spain. The prognosis was unfavorable.

CASE 6. A native of Russia. Age 32 years. A married man.

This patient landed at Philadelphia in 1900 and had been in New York City only 3 months. The diagnosis was gonorrheal infection, with history of the same trouble 4 years prior to admission and syphilis 3 years before. This patient had been earning $15.00 a week, but had been unemployed for 2½ months. The prognosis was unfavorable.

CASE 7. A native of Russia. Age 29 years. A married man.

This patient landed at New York in 1906. The diagnosis was chronic articular rheumatism of 4 months existence. He had been in a municipal hospital 6 months previously. He had earned $13.00 a week when employed, and had a wife and a small child dependent upon him. The prognosis was unfavorable.

CASE 8. A native of Ireland. Age 29 years. A single woman.

This patient landed at New York in 1900. The diagnosis was chronic alcoholism and toxic psychosis. The extent of her alcoholic history could not be determined. Her only relative in this country was a brother. The prognosis was unfavorable.

CASE 9. A native of Russia. Age 25 years. A married man.

This patient landed at New York in March, 1906. The diagnosis was chronic pulmonary tuberculosis, with acute history of 2 months. He was transferred to a tuberculosis hospital. He had earned $12.00 to $16.00 a week when employed, but had been out of work for 2 months. He had a wife and 2 small children dependent upon him. The prognosis was unfavorable.

CASE 10. A native of Norway. Age 61 years. A married man.

This patient landed at New York as a seaman in 1907 and had assumed employment on dredges. The diagnosis was gastric ulcer, of some months existence. The prognosis was unfavorable.

CASE 11. A native of Poland. Age 28 years. A single man.

This patient landed at New York in July, 1906. The diagnosis was chronic pulmonary tuberculosis and alcoholism. He earned $12.00 to $16.00 a week when employed, but had been ill for 3 months prior to admission. His only relative in this country was a brother, earning $11.00 a week. The prognosis was unfavorable.

CASE 12. A native of Italy. Age 24 years. A single man.

This patient landed at New York November 27, 1912. The diagnosis was gonorrheal infection. He had been unable to work for 3 weeks prior to admission because of sickness. The prognosis was unfavorable.

CASE 13. A native of Greece. Age 21 years. A single man.

This patient landed at New York in February, 1908. The diagnosis was chronic pulmonary tuberculosis. He had lived only 9 months in New York City and previously had been in Massachusetts for 4 years. All his relatives were in Europe. He had earned $10.00 a week when employed. The prognosis was unfavorable.

CASE 14. A native of Australia. Age 28 years. A single man.

This patient landed at New York in December, 1903. The diagnosis was syphilis of the spinal cord. He had a syphilitic history for the previous 3 years. He had been employed in New York hospitals for 2 months previous to admission and prior to that time had been 4 years in Philadelphia. All his relatives were in England. He had no savings. The prognosis was unfavorable.

CASE 15. A native of Ireland. Age 29 years. A single man.

This patient landed at New York in October, 1902. The diagnosis was chronic alcoholism. This patient was a "repeater" at this Hospital. He had made $3.00 a day as a blacksmith, but his employment was irregular. The prognosis was unfavorable.

CASE 16. A native of Ireland. Age 25 years. A single woman.

This patient landed at New York in July, 1904. She was pregnant, although unmarried. She was in a generally poor physical condition and had had a cough for 2 months. She had earned $14.00 a month and board as a domestic when employed, but had been unemployed for 1 month prior to admission and had no savings. She had previously been a patient in a municipal hospital. Her mother lived in Ireland. She had 1 sister, who was a hotel employee in New York. The prognosis was unfavorable.

CASE 17. A native of Russia. Age 26 years. A married man.

This patient landed at New York in April, 1908. The diagnosis was chronic interstitial nephritis. His only relative in this country was a brother. His father lived in Russia. He died in the Hospital.

CASE 18. A native of Russia. Age 21 years. A single man.

This patient landed at New York in August, 1908. The diagnosis was chronic pulmonary tuberculosis, with history of 3 months prior to entering the Hospital. He had been out of work 6 months and had no savings. His sister, a married woman, was the only relative he had in this country. His parents lived in Europe. He was transferred to a tuberculosis hospital for further treatment. The prognosis was unfavorable.

CASE 19. A native of Italy. Age 35 years. A married man.

This patient landed in the United States in 1905. He came to New York from Oklahoma May 20, 1913, on his way back to Italy. The diagnosis was chronic alcoholism and chloral poisoning. While in an intoxicated condition he had been given chloral poison and had been robbed. The prognosis was unfavorable.

CASE 20. A native of Greece. Age 21 years. A single man.

This patient landed at New York in February, 1908. The diagnosis was chronic pulmonary tuberculosis. This was at least his second admission to Bellevue Hospital. He had lived only 9 months in New York City, and previously in Massachusetts for 4 years. All his relatives were in Europe. He had earned $10.00 a week when employed. The prognosis was unfavorable.

CASE 21. A native of Ireland. Age 65 years. A single woman.

This patient landed at New York about 1880. The diagnosis was chronic parenchymatous nephritis of 2 or 3 years existence. She had spent 2 winters in a municipal institution. She had no means of making a livelihood and was dependent upon friends and public charity. The prognosis was unfavorable.

CASE 22. A native of Russia. Age 22 years. A single man.

This patient landed at New York in June, 1907. He was brought to the Hospital by a representative of the State Board of Charities. The diagnosis was chronic pulmonary tuberculosis, with an illness of about 2 years existence. He was to be deported May 24, 1913, and was discharged to the State Board of Charities.

CASE 23. A native of Austria. Age 26 years. A single woman.

This patient landed at New York in 1906. She had been admitted to the Hospital for parturition. She was out of employment and without any funds, and had no one in this country who could give her any assistance. Her mother was living in Europe. The prognosis was unfavorable.

CASE 24. A native of Greece. Age 30 years. A single man.

This patient landed at New York in 1907. He was suffering from venereal disease of apparently recent history and a lengthy treatment was indicated as necessary. He earned $7.00 or $8.00 a week when employed, but had no savings at the time of admission to the Hospital. He had no relatives in this country. The prognosis was unfavorable.

CASE 25. A native of Bermuda. Age 39 years. A single man.

This patient landed at New York in 1901. His history showed that he had had syphilis for 5 years. He had been out of work for some time and had no savings at the time of admission to the Hospital. He had no relatives in this country. The prognosis was unfavorable.

CASE 26. A native of Ireland. Age 36 years. A married woman.

This patient landed at New York in 1887. The diagnosis was chronic alcoholism and cardiac valvular disease. She had no knowledge of her husband's whereabouts and had no other relatives in this country excepting a small child. The prognosis was unfavorable.

CASE 27. A native of Ireland. Age 40 years. A single woman.

This patient landed at New York in 1907. The diagnosis was chronic arthritis, involving right and left knees, of 3 months existence. She had been out of work 4 months before admission to the Hospital. She had no savings and had no relatives in this country. The prognosis was unfavorable.

CASE 28. A native of Ireland. Age 34 years. A married woman.

This patient landed at New York May 2, 1901. She was separated from her husband. The diagnosis was chronic alcoholism. She had been addicted to the use of alcohol for a few years. She had no steady occupation. Her income was uncertain and upon admission to the Hospital she had no savings. Her child, 6 years old, was in a charitable institution. The prognosis was unfavorable.

CASE 29. A native of Ireland. Age 56 years. A single man.

This patient landed at New York in 1902. The diagnosis was chronic alcoholism. This was at least the second instance of the patient's dependence. He earned $5.00 a week when employed, but had no funds at the time of admission to the Hospital. He had no relatives in the United States. The prognosis was unfavorable.

CASE 30. A native of West Indies. Age 28 years. A single man.

This patient landed at New York in April, 1906. The diagnosis was chronic pulmonary tuberculosis. His illness had been acute for 6 months before entering the Hospital, which prevented him from doing any work. He had no savings. His brother in this country was too poor to give him any material assistance. The prognosis was unfavorable.

CASE 31. A native of Ireland. Age 28 years. A single man.

This patient landed at New York in September, 1901, and came to this State from Ohio in 1913. The diagnosis was chronic alcoholism, with an alcoholic history for 8 years. He had been out of work for some time and had no savings at the time of admission to the Hospital. He had no relatives in this country. The prognosis was unfavorable.

CASE 32. A native of Ireland. Age 27 years. A single man.

This patient landed at Boston in 1903 and came to New York from Boston 3 days before admission to the Hospital. The diagnosis was chronic alcoholism. He had been addicted to the use of alcohol for some time and at one time had been a patient in the public hospital in Boston with delirium tremens. He had been out of work and had no savings. His sister lived in Boston. The prognosis was unfavorable.

CASE 33. A native of Ireland. Age 35 years. A single man.

This patient landed in the United States in 1897. In May, 1913, he came to this City from New Jersey, where he had lived for 8 years. The diagnosis was fracture of the vertebræ, received on the day of admission to the Hospital. He had been out of work for 2 weeks prior to admission to the Hospital and had no savings. He had no relatives in this country. The prognosis was unfavorable.

CASE 34. A native of Russia. Age 47 years. A married man.

This patient landed at Quebec, Canada, in 1909 and came directly to settle in New York City. The diagnosis was chronic pulmonary tuberculosis, with a history of 1 year of acute illness. After a short stay in the Hospital he was transferred to a tuberculosis hospital. He had been out of work for 6 weeks before entering Bellevue Hospital. His wife and 5 minor children, under 13 years, living in Europe, were dependent upon him for support. He had no savings and had no relatives in this

country. He was deported by the State Board of Charities. The prognosis was unfavorable.

CASE 35. A native of Russia. Age 21 years. A single woman.

This patient landed at New York in October, 1910. The diagnosis was chronic pulmonary tuberculosis, with a history of 2 years existence. During almost all of this time she had been an inmate of a tuberculosis institution. She had been out of employment since 1911. She was transferred from Bellevue to a tuberculosis hospital. Her parents were dead. One sister earned $8.00 a week, another sister was a tuberculosis patient, and a younger sister was in a home. The prognosis was unfavorable.

CASE 36. A native of Greece. Age 21 years. A single man.

This patient landed at New York in February, 1908. The diagnosis was chronic pulmonary tuberculosis. This was at least his second admission to Bellevue Hospital. He had lived only 9 months in New York City and previously had been in Massachusetts for 4 years. All of his relatives were in Europe. He earned $10.00 a week when employed. The prognosis was unfavorable.

CASE 37. A native of Russia. Age 24 years. A single man.

This patient landed at New York in 1910. The diagnosis was venereal disease, of recent contraction. He had no relatives in this country and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 38. A native of Germany. Age 30 years. A single man.

This patient landed at New York in July, 1911. The diagnosis was acute rheumatic fever. He had 9 days previously been discharged from a hospital after 5 weeks treatment for rheumatism. This man had no relatives in this country and no savings, as he had been out of work for some time. The prognosis was unfavorable.

CASE 39. A native of England. Age 26 years. A widow.

This patient landed at New York in September, 1905. The diagnosis was chronic pulmonary tuberculosis. She had been working in the millinery trade and supporting herself and 5-year-old child. She had no savings at the time of admission to the Hospital. The only relative in this country was a sister who earned $6.00 a week. Her father lived in England. The prognosis was unfavorable.

CASE 40. A native of Scotland. Age 24 years. A married man.

This patient landed at New York in 1904. The diagnosis was secondary syphilis, with a history of 3 months existence. He also had cardiac disease. This was at least his second admission to Bellevue Hospital. He had no savings. He had 2 married brothers and 1 sister, a silk weaver, in this country. His parents were living in Scotland. The prognosis was unfavorable.

CASE 41. A native of Russia. Age unknown. A single man.

This patient landed at New York in July, 1910. The diagnosis was chronic pulmonary tuberculosis, with a history of 6 weeks acute illness. He was transferred to a tuberculosis hospital. He had been out of work 3 months prior to admission to the Hospital and had no savings. He had 3 brothers and a married sister in this country. His parents were living in Europe. The prognosis was unfavorable.

CASE 42. A native of Ireland. Age 34 years. A single man.

This patient landed at New York in September, 1901. The diagnosis was chronic alcoholic poisoning, with an alcoholic history for 9 years. This man had been out of work 4 months and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 43. A native of Greece. Age 32 years. A single man.

This patient landed at New York June 5, 1910. The diagnosis was pulmonary tuberculosis, with a history of acute illness for 6 months. He was transferred to a tuberculosis hospital. He had no relatives in this country and had been out of work 4 months. He expressed a desire to be returned to Italy. The prognosis was unfavorable.

CASE 44. A native of Ireland. Age 37 years. A single man.

This patient landed at New York June 7, 1908. The diagnosis was alcoholic poisoning and old mastoiditis. He had been an inmate of a municipal hospital for 11

weeks for an operation. He had no savings. He had 1 brother, a laborer, in the City. The prognosis was unfavorable.

CASE 45. A native of Germany. Age 24 years. A single man.

This patient landed at New York as a discharged seaman in March, 1909. He lived in various states and came to New York a few months before admission to the Hospital. The diagnosis was subacute rheumatism with cardiac involvement. The history showed that he had been treated at Bellevue on a previous occasion for the same ailment He had been out of work for a length of time and had no savings. The prognosis was unfavorable.

CASE 46. A native of Ireland. Age 25 years. A single man.

This patient landed at New York in April, 1908. The diagnosis was pulmonary tuberculosis. He had no savings at the time of admission to the Hospital and had no relatives in this country. The prognosis was unfavorable.

CASE 47. A native of Germany. Age 41 years. A single man.

This patient landed at New York about 1893. The diagnosis was epilepsy. The history showed that he had been an inmate of a municipal hospital for 8 months. He had been unable to earn his living for the past 3 years. He lived in lodging houses. His only relative in this country was a brother. The prognosis was unfavorable.

CASE 48. A native of Austria. Age 25 years. A single man.

This patient landed at New York in May, 1903. The diagnosis was gonorrheal infection and syphilis, with a syphilitic history for the previous 6 years. This man was a recurrent dependent and had been in Bellevue Hospital previously. He was transferred to a chronic hospital. He had been unemployed 3 months and had no savings. His only relative in this country was a sister, who was working in a factory. His parents lived in Europe. The prognosis was unfavorable.

CASE 49. A native of Ireland. Age 40 years. A single woman.

This patient landed at New York in 1888. The diagnosis was chronic alcoholism and fracture of femur. The alcoholic history covered many years. She was a recurrent dependent and also had a workhouse record. She was a domestic irregularly employed. She had no relatives in this country. The prognosis was unfavorable.

CASE 50. A native of Ireland. Age 45 years. A single man.

This patient landed at New York in 1899. The diagnosis was syphilis, with a syphilitic history for 7 years, and chronic gonorrhea. He was transferred to a chronic hospital. He lived in lodging houses. The only relative in this country was a brother, who was out West. The prognosis was unfavorable.

CASE 51. A native of Italy. Age 40 years. A single man.

This patient landed at New York in September, 1899. The diagnosis was chronic pulmonary tuberculosis, with a history of 4 weeks acute illness. He was transferred to a chronic hospital. He had been out of work 4½ months and had no savings at the time of admission to the Hospital. He had 2 married sisters in this country. His parents were living in Europe. The prognosis was unfavorable.

CASE 52. A native of Austria. Age 18 years. A single woman.

This patient landed at New York in May, 1912. The diagnosis was pregnancy, of a few weeks existence. She had been out of work for some time and had no savings at the time of admission to the Hospital. Her parents lived in Europe and she had no relatives in this country. The prognosis was favorable.

CASE 53. A native of Russia. Age 30 years. A married man.

This patient landed at New York in April, 1911. He came to this City from Paterson to be admitted to the Hospital. The diagnosis was chronic gonorrhea and inguinal abscess, with a history of contraction of 8 months before. He was transferred to a chronic hospital. He had a wife dependent upon him for support and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 54. A native of Scotland. Age 38 years. A married woman, separated from her husband.

This patient landed at New York, December, 1899. The diagnosis was secondary syphilis, with a syphilitic history for 3 months. She had been out of work for 2 weeks prior to admission to the Hospital and had no savings. The prognosis was unfavorable.

CASE 55. A native of Russia. Age 28 years. A single man.

This patient landed at New York in May, 1905. The diagnosis was chronic alcoholism. He had been a patient in a public hospital for 2 months at a previous time. His parents were living in Russia. He had 2 brothers, who were laborers, living in this country. The prognosis was unfavorable.

CASE 56. A native of Russia. Age 32 years. A single man.

This patient landed at New York in April, 1908. The diagnosis was chronic pulmonary tuberculosis, with a history of 8 months of acute symptoms. This patient had been unemployed for about 4 months prior to admission to the Hospital and had no savings. The only relative in this country was a brother. The prognosis was unfavorable.

CASE 57. A native of Italy. Age 28 years. A single man.

This patient landed at New York in October, 1901. He had lived in New York City only 6 months before admission to the Hospital. The diagnosis was chronic alcoholism, with an alcoholic history for 6 years. He had previously been in Bellevue for alcoholism. This patient was irregularly employed and had no savings at the time of admission to the Hospital. The only relatives in this country were 2 brothers in Montana. The prognosis was unfavorable.

CASE 58. A native of Italy. Age 26 years. A single man.

This patient landed at New York in March, 1910. The diagnosis was pulmonary tuberculosis, with a history of acute symptoms for 2 months. He was transferred to a chronic hospital. He had earned $8.00 a week when employed. He had been out of work for some time and had no savings at the time of admission to the Hospital. All of his relatives were living in Europe. The prognosis was unfavorable.

CASE 59. A native of Russia. Age 22 years. A single woman.

This patient landed at New York in 1906. The diagnosis was chronic gastric neurasthenia and prolapse of the internal organs. The history showed that she had had gastric trouble for the preceding 4 years. She had an operation in 1910, and 2 subsequent operations for adhesions. She had been out of work 6 months and had no savings at the time of admission to the Hospital. She had been treated at Bellevue Hospital on a previous occasion. The only relative in this country was a sister, who earned very little. Her parents were living in Russia. The prognosis was unfavorable.

CASE 60. A native of Ireland. Age 46 years. A single woman.

This patient landed at New York in 1887. The diagnosis was chronic alcoholism of undetermined extent. She had no regular occupation and had no relatives in this country. At time of admission to the Hospital she had no savings. The prognosis was unfavorable.

CASE 61. A native of Italy. Age 23 years. A single man.

This patient landed at New York in August, 1912. The diagnosis was acute pericarditis and acute rheumatic fever. He had 2 sisters in this country. At the time of admission to the Hospital he had no savings. The prognosis was unfavorable.

CASE 62. A native of Germany. Age 21 years. A single woman.

This patient landed at New York in December, 1910. The diagnosis was abortion. Her mother and 6 brothers lived in Europe. A brother was the only relative in this country. The medical prognosis was favorable.

CASE 63. A native of Russia. Age 30 years. A single man.

This patient landed at New York in 1908 as a second-class passenger. The diagnosis was syphilis, with a history of 6 weeks existence. He had earned $9.00 a week, but at the time of admission to the Hospital he had been out of work 2

weeks. He had been admitted previously to the Hospital. He had no relatives in this country. The prognosis was unfavorable.

CASE 64. A native of Ireland. Age 28 years. A single man.

This patient landed at New York in August, 1901. The diagnosis was chronic alcoholism, with an alcoholic history for 9 years. He had been out of work 7 weeks and had no savings. His brother, a bartender, was the only relative living in this country. His parents were living in Ireland. The prognosis was unfavorable.

CASE 65. A native of Austria. Age 19 years. A single woman.

This patient landed at New York March 6, 1912. The diagnosis was acute rheumatism and acute endocarditis. Her parents were living in Austria. She had 1 sister in this City, a domestic, earning $4.00 a week. She had been out of work for 2 weeks prior to admission to the Hospital. The prognosis was unfavorable.

CASE 66. A native of Russia. Age 30 years. A married man.

This patient landed at New York in 1910. The diagnosis was chronic pulmonary tuberculosis. He had been acutely ill for about 7 months. He had been unemployed for 2 months prior to admission to the Hospital. His wife was dependent upon him for support. The prognosis was unfavorable.

CASE 67. A native of Italy. Age 27 years. A single man.

This patient landed at New York in 1903. The diagnosis was chronic pulmonary tuberculosis with tubercular laryngitis, with a history of 5 months acute illness. He was a chronic invalid. He had been out of work for 6 months before admission to the Hospital and had no savings. His parents were living in Italy. He had no relatives in this country. The prognosis was unfavorable.

CASE 68. A native of Ireland. Age 40 years. A single woman.

This patient landed at New York in 1897. The diagnosis was alcoholism, with a history of at least 5 admissions to the alcoholic ward at Bellevue. This patient had been out of work for at least 3 weeks and had no savings. The only relative in this country was a brother. Her mother was living in Ireland. The prognosis was unfavorable.

CASE 69. A native of Spain. Age 23 years. A single woman.

This patient landed at New York February 22, 1912. The diagnosis was parturition. She had been out of work for some time before admission to the Hospital and had no savings. Her mother was living in Spain. The medical prognosis was favorable.

CASE 70. A native of Germany. Age 37 years. A single man.

This patient landed at New York December 29, 1894. The diagnosis was locomotor ataxia with cerebro-spinal syphilis. The history showed gonorrheal infection 14 years before and syphilis infection 9 years before. He had no relatives in this country. His parents were living in Germany. He had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 71. A native of Russia. Age 24 years. A single man.

This patient landed at San Francisco, California, in August, 1908. He had been in New York State only 10 months and in the City only 3 months before admission to the Hospital. The diagnosis was malaria and quinine poisoning. The history showed that he had a similar condition a year before. He had been out of work 3 months and was unable to pay for the medical treatment and maintenance he received at the Hospital. The prognosis was unfavorable.

CASE 72. A native of Austria. Age 29 years. A single woman.

This patient landed at New York in 1904. The diagnosis was parturition. She already had a child 5 years old. She had no savings at the time of admission to the Hospital and had no relatives other than her child in this country. Her parents were living in Austria. The medical prognosis was favorable.

CASE 73. A native of Ireland. Age 47 years. A single man.

This patient landed at New York in 1888. The diagnosis was chronic alcoholism, with an alcoholic history for many years. He had no savings at time of admission to

the Hospital. This patient had 1 married sister in this country. The prognosis was unfavorable.

CASE 74. A native of Hungary. Age 25 years. A single man.

This patient landed at New York January 5, 1907. The diagnosis was neurasthenia. He had earned only $8.00 a week when employed. He had no relatives in this country. His parents were living in Hungary. The prognosis was unfavorable.

CASE 75. A native of Germany. Age 51 years. A single man.

This patient landed at New York in 1888. He came from New Jersey, where he had his residence. The diagnosis was chronic pulmonary tuberculosis, with a tubercular history for 8 years and a record of 6 admissions to one New York tuberculosis hospital. This patient had been unemployed for a year and a dependent on charity. He had no relatives in this country. The prognosis was unfavorable.

CASE 76. A native of Ireland. Age 65 years. A single woman.

This patient landed at New York about 1858. She came from New Jersey, where she had settled prior to admission to the Hospital. The diagnosis was chronic pulmonary tuberculosis, with a history of several years existence. She had been previously admitted for the same disease at Bellevue Hospital and other hospitals. She had been unable to work for a year and had no relatives in this country. The prognosis was unfavorable.

CASE 77. A native of Italy. Age 25 years. A married woman.

This patient landed at New York in September, 1910. The diagnosis was chronic pulmonary tuberculosis. She was transferred to a tuberculosis hospital. She had 2 small children. Her husband was unable to pay for the medical treatment and maintenance she received at the Hospital. The prognosis was unfavorable.

CASE 78. A native of Austria. Age 39 years. A widow.

This patient landed at New York in 1901. The diagnosis was chronic alcoholism, with an alcoholic history for 6 years. She was a domestic and had no savings at the time of admission to the Hospital. She had been previously admitted to Bellevue for alcoholism. She had no relatives in this country. The prognosis was unfavorable.

CASE 79. A native of Ireland. Age 58 years. A single woman.

This patient landed at New York about 1900. The diagnosis was chronic polyarthritis. She had previously been treated at a public hospital in New York. She had been unable to work steadily for the last 10 years because of the condition of her health. She had no relatives in this country and had lost all of her savings. The prognosis was unfavorable.

CASE 80. A native of India. Age 21 years. A single man.

This patient landed at New York January 22, 1913, as a second-class passenger. The diagnosis was acute rheumatic fever with myo-endocarditis. This was his second admission to Bellevue. He had been out of work 3 weeks and had no savings. He had no relatives in this country. The prognosis was unfavorable.

CASE 81. A native of Austria. Age 20 years. A single woman.

This patient landed at New York in March, 1911. The diagnosis was pregnancy. She had been out of work 5 months prior to admission to the Hospital and had no savings. Her father lived in Perth Amboy, N. J. Her mother was living in Austria. The medical prognosis was favorable.

CASE 82. A native of Hungary. Age 50 years. A widow.

This patient landed at New York August 18, 1911. The diagnosis was hysteria and old fracture of hip joint. She walked on crutches. She had previously been an inmate of numerous City institutions. Her employment was irregular. She had no savings and no relatives in this country. The prognosis was unfavorable.

CASE 83. A native of Ireland. Age 32 years. A single man.

This patient landed at New York in April, 1903. The diagnosis was alcoholism, with delirium tremens and cirrhosis of liver. The history showed that he had previously been in the alcoholic ward at Bellevue. He had been out of work 3 weeks

and had no savings at the time of admission to the Hospital. He had 2 brothers living in New York. His mother was living in Ireland. The prognosis was unfavorable.

CASE 84. A native of Ireland. Age 35 years. A single woman.

This patient landed at New York in September, 1897. The diagnosis was chronic pulmonary tuberculosis, with a history indicating that the disease was contracted subsequent to landing. She had been a patient for 3 months in a tuberculosis hospital. She was without any means of support. She had 1 married sister in this country. Her father was living in Ireland. The prognosis was unfavorable.

CASE 85. A native of Austria. Age 19 years. A single woman.

This patient landed at New York in 1907. The diagnosis was hysteria. The history indicated unstable mentality. She had 3 previous admissions to Bellevue and 4 to other public hospitals. She had a sister and brother in this country. Her parents were living in Austria. The prognosis was unfavorable.

CASE 86. A native of Turkey. Age 24 years. A single man.

This patient landed at New York in 1898. He came to New York from New Jersey, where he resided, the day of admission to the Hospital. He had never lived in New York. The diagnosis was tenosynovitis, with a history of 7 years existence. He was discharged in an unimproved condition and returned to the Hospital a week later. He earned $15.75 a week, but had no savings. His parents were dependent upon him. The prognosis was unfavorable.

CASE 87. A native of Ireland. Age 24 years. A widow.

This patient landed at New York in 1904. The diagnosis was pregnancy. She had 2 children dependent upon her for support. Before admission to the Hospital she worked in a pencil factory and earned $5.00 a week. Her parents were living in Ireland. A brother, who earned very little, was the only relative in this country. The medical prognosis was favorable.

CASE 88. A native of Italy. Age 24 years. A single man.

This patient landed at New York in 1907. The diagnosis was tuberculosis of genital organs, which the history indicated had apparently been of recent origin. He had earned only $10.00 a week when employed. He did not know the whereabouts of his sister and brother, who were living in this country. The prognosis was unfavorable.

CASE 89. A native of Russia. Age 21 years. A single woman.

This patient landed at New York in April, 1906. The diagnosis was carcinoma of rectum and almost the entire genito-urinary system. The patient also had an artificial anus. She had previously been a patient for 4 months in a public hospital. The history showed that her condition had originated at least 2 years before. She had been out of work since 1910. She lived with her parents in this country, but they were unable to pay for the medical treatment she received at the Hospital. There were 6 in the family and the income was $10.00 a week, with $3.00 a month from a lodger. She was transferred in an unimproved condition to a chronic hospital. The prognosis was unfavorable.

CASE 90. A native of Germany. Age unknown. A single man.

This patient landed at New York in 1902. The diagnosis was pulmonary tuberculosis, with a history of 3 years existence. He had been an inmate of a public institution for 2½ years before. He had a very irregular income. His parents were living in Europe. He had 1 brother in this country, who worked for small wages. The prognosis was unfavorable.

CASE 91. A native of Italy. Age 19 years. A married woman, deserted by her husband 2 years before admission.

This patient landed at New York in 1903. The diagnosis was chronic endometritis, with chronic gonorrhea. The history indicated gonorrheal contraction of 4 years before. She had worked in a factory and earned $5.00 a week. At the time of admission to the Hospital she had no savings. Her mother and a married sister lived in New York State. The prognosis was unfavorable.

CASE 92. A native of Ireland. Age 46 years. A married man.

This patient landed at New York in 1900. The diagnosis was chronic pulmonary tuberculosis and old ischiorectal abscess, with chronic discharging sinus. He was transferred in an unimproved condition to a chronic hospital. He had previously been an inmate at a public hospital for 6 months. He had been out of work since January, 1913. His parents were living in Ireland. The prognosis was unfavorable.

CASE 93. A native of Austria. Age 47 years. A single man.

This patient landed in the United States in July, 1905. He came to New York 3 months before admission to the Hospital. The diagnosis was chronic pulmonary tuberculosis, of about 2 years existence. He earned $7.00 a week, but had no savings, and no relatives in this country. He was transferred to a tuberculosis hospital. His father was living in Austria. He had expected to return shortly. The prognosis was unfavorable.

CASE 94. A native of Germany. Age 50 years. A widower.

This patient landed at Baltimore, Md., in April, 1910. The diagnosis was neurasthenia and gastritis. He had no savings at the time of admission to the Hospital. His relatives were in Europe. He said that he was going back to Germany in the fall. He was, upon discharge, referred to the Department of Public Charities for institutional care. The prognosis was favorable.

CASE 95. A native of Italy. Age 34 years. A married man.

This patient landed at New York in June, 1908. The diagnosis was chronic fibrinous pleurisy, with effusion of 2 months existence. He had been out of work for 2 months prior to admission and had no savings. His wife earned $4.00 a week. Three small children were dependent upon them. The prognosis was unfavorable.

CASE 96. A native of Russia. Age 28 years. A single man.

This patient landed at Boston, Mass., in 1907. The diagnosis was facial erysipelas. He had previously been treated at hospitals in Boston and New York City. He had been out of work for 6 months prior to admission and had no savings. He had no relatives in this country. The prognosis was favorable.

CASE 97. A native of Hungary. Age 29 years. A married man.

This patient landed at New York in December, 1906. The diagnosis was empyema, with a history of 6 weeks existence, originating from attempted suicide. He had been out of work for weeks at the time of admission to the Hospital and had no savings. His only relative in this country, a brother, earned $8.00 a week. His parents were living in Europe. The prognosis was unfavorable.

CASE 98. A native of Russia. Age 47 years. A single man.

This patient landed at New York in 1902. The diagnosis was chronic pulmonary tuberculosis of 1½ years existence. He had previously been a patient in a municipal hospital. He was an unskilled laborer and earned $5.00 a week. He had no savings and no relatives in this country. The prognosis was unfavorable.

CASE 99. A native of Sweden. Age 21 years. A single man.

This patient landed at New York January 25, 1912, and went to Ohio. He came from Chicago, Ill., about 1 month prior to admission to the Hospital. The diagnosis was chronic gonorrhea, with a history of 3 months existence. He had been out of work for some time and had no savings. A sister, in California, was the only relative in this country. His parents were living in Sweden. The prognosis was unfavorable.

CASE 100. A native of Hungary. Age 38 years. A married woman.

This patient landed at New York in February, 1901. The diagnosis was chronic pulmonary tuberculosis, with a history of 8 years existence. She had previously been in Bellevue for 10 days and had been in a tuberculosis hospital for 7 weeks. She was transferred to a tuberculosis hospital. Her husband earned $10.00 a week and was unable to pay for her medical treatment. In view of this patient's long stay in this country, it might be questioned whether it would be humane to deport her. The prognosis was unfavorable.

CASE 101. A native of Ireland. Age 46 years. A single man.

This patient landed at Philadelphia in 1900. He came to this city from Florida a week before his admission to the Hospital. The diagnosis was chronic pulmonary

tuberculosis, with a history of 12 months existence. He had been out of work 2 months, and had no relatives in this country. He was transferred in an unimproved condition to a tuberculosis hospital. The prognosis was unfavorable.

CASE 102. A native of Austria. Age 23 years. A single woman.

This patient landed at New York in February, 1908. The diagnosis was parturition. At the time of admission to the Hospital she had no savings. Her parents were living in Austria and she had no relatives in this country. The medical prognosis was favorable.

CASE 103. A native of Italy. Age 33 years. A single man.

This patient landed at New York in 1904. The diagnosis was inguinal hernia, which had appeared after heavy lifting 1 month previous to admission to the Hospital. He was discharged in an unimproved condition. This man did not pay for his maintenance at the Hospital. The only relative in this country was a brother. His mother was living in Italy. The prognosis was favorable.

CASE 104. A native of West Indies. Age 17 years. A single man.

This patient landed at New York in August, 1911. The diagnosis was syringomyelia, with a history of illness since November, 1912. This patient had been out of work 5 months and had no savings. The only relative in this country was a brother. His parents were living in the West Indies Islands. The prognosis was unfavorable and indicated a progressive condition.

CASE 105. A native of Austria. Age 28 years. A single woman.

This patient landed at New York in November, 1910. The diagnosis was parturition. She had been out of work for 2 months prior to admission to the Hospital and had no savings. She had no relatives in this country. The medical prognosis was favorable.

CASE 106. A native of Russia. Age 40 years. A married man.

This patient landed at New York in December, 1908. The diagnosis was chronic pulmonary tuberculosis, with a history of 3 years existence. He had been out of work for a month prior to admission and had no savings. His wife, a dressmaker, earned about $3.00 a week. They had 1 dependent child. The prognosis was unfavorable.

CASE 107. A native of Ireland. Age 40 years. A single man.

This patient landed at New York in March, 1897. He came to this City about 2 months prior to admission to the Hospital, from Norwich, Conn., where he had lived for 16 years. The diagnosis was syphilis of lungs, with a history of respiratory illness for 3 months. He had contracted syphilis 3 years before. He had been out of work and could not pay for his maintenance at the Hospital. He had been living in various lodging houses and had previously been treated at a New York City municipal hospital. The prognosis was unfavorable.

CASE 108. A native of Russia. Age 33 years. A single man.

This patient landed at New York October 3, 1904. He came to New York City about 2 months prior to admission to the Hospital, from Chicago, Ill., where he had lived 2½ years. The diagnosis was chronic tuberculous arthritis, with a history of 5 years existence. He had previously been a patient in a public hospital in Chicago, Ill., for 5 months. He had been out of work 3 months and had no savings at the time of admission to the Hospital. He had 2 married sisters in Chicago. The prognosis was unfavorable.

CASE 109. A native of Austria. Age 31 years. A married man.

This patient landed at New York in April, 1913. The diagnosis was fracture of pelvis and os calcis. After 10 days stay at Bellevue he was transferred to a chronic hospital. He had no savings. His wife and 4 dependent children were living in Austria. The prognosis was unfavorable.

CASE 110. A native of Germany. Age 29 years. A single woman.

This patient landed at New York October 3, 1910, and went to Missouri. The diagnosis was chronic pulmonary tuberculosis, with a history of 3 months of acute illness. She came to this City 2 months previous to admission to Bellevue on her way back to Germany. She was transferred to a tuberculosis hospital. She had ex-

pended all her savings during her illness in New York City. She had no relatives in this country. The prognosis was unfavorable.

CASE 111. A native of Austria. Age 20 years. A single woman.

This patient landed at New York in March, 1910. The diagnosis was parturition. She had been a patient at Bellevue a month before. The history showed that she had also given birth to a child 2 years before. Her father lived in New Jersey and her mother in Austria. The medical prognosis was favorable.

CASE 112. A native of Ireland. Age 25 years. A single man.

This patient landed at New York October 24, 1909, and went to Florida. The diagnosis was chronic pulmonary tuberculosis and fistula in ano, with a history of 6 months of acute illness. He was transferred to a tuberculosis hospital. He had been out of work for a month prior to admission to the Hospital and had no savings. His only relatives in this country were 2 married sisters. His parents were living in Ireland. The prognosis was unfavorable.

CASE 113. A native of Russia. Age 50 years. A married man.

This patient landed at New York in July, 1909. The diagnosis was chronic pulmonary tuberculosis, with a history of 5 months of acute illness. He was transferred to a tuberculosis hospital as unimproved. He had 3 daughters, working in a factory and earning from $5.00 to $8.00 a week each. His wife was living in Europe. He had been out of work 4 weeks and had no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 114. A native of Russia. Age 28 years. A married man.

This patient landed at New York in January, 1909, and came to this City from Wisconsin 3 months prior to admission to the Hospital. The diagnosis was pulmonary tuberculosis, with a history of 6 weeks of acute illness. He had been out of work for 6 weeks prior to entering the Hospital and had no savings. His wife was unable to help him. The only other relative in this country was a brother, who earned $16.00 a week. His parents were living in Russia. The prognosis was unfavorable.

CASE 115. A native of Hungary. Age 33 years. A married man.

This patient landed at New York in 1902. The diagnosis was syphilis, with a history of ulcers for 2 or 3 months. He had been out of work 6 weeks and had no savings at the time of admission to the Hospital. He had 2 children dependent upon him. His wife had deserted him some time before. He had no other relatives in this country. His parents were living in Hungary. The prognosis was unfavorable.

CASE 116. A native of Ireland. Age 30 years. A single man.

This patient landed at New York in June, 1907. The diagnosis was chronic alcoholism, with an alcoholic history for 4 years. He was an unskilled laborer and had been unemployed for 1 week prior to admission to the Hospital. He had no savings and was unable to pay for the medical treatment at the hospital. His parents were living in Ireland. The only relative in this country was a sister. The prognosis was unfavorable.

CASE 117. A native of Russia. Age 36 years. A married man.

This patient landed at New York in January, 1904. The diagnosis was pre-senile gangrene of the foot, with a history of 5 years contributing condition. He had been out of work for 6 weeks prior to admission to the hospital. His wife was dependent upon him. He had no other relatives in this country. His father was living in Russia. The prognosis was unfavorable.

CASE 118. A native of Turkey. Age 24 years. A single man.

This patient landed at New York in 1898. He came to New York from New Jersey for treatment. He had never lived in New York City. The diagnosis was tenosynovitis, with a history of 7 years existence. He had previously been a patient at Bellevue. He earned $15.75 a week, but had no savings. His parents were dependent upon him. The prognosis was unfavorable.

CASE 119. A native of Ireland. Age 40 years. A single woman.

This patient landed at New York in 1898. The diagnosis was syphilis. She was transferred to a chronic hospital. She had no relatives in this country. The prognosis was unfavorable.

CASE 120. A native of Russia. Age 17 years. A single woman.

This patient landed at New York in March, 1912. The diagnosis was parturition. She had been a patient at Bellevue Hospital 6 months before. She had been out of work 3 months and had no savings at the time of admission to the Hospital. The only relative in this country was a brother, who earned $16.00 a week. The medical prognosis was favorable.

CASE 121. A native of Russia. Age 20 years. A single man.

This patient landed at New York in 1910. The diagnosis was valvular cardiac disease, with history of acute illness for 1 week before admission. His relatives were living in Russia. He had been out of work at the time of admission to the Hospital and had no savings. The prognosis was unfavorable.

CASE 122. A native of Russia. Age 23 years. A single man.

This patient landed at Baltimore in 1908. The diagnosis was chronic pulmonary tuberculosis, with a history of acute illness for 1 year. The history showed that his mother died of tuberculosis. He earned only $6.00 a week and had been out of work a week prior to the admission to the Hospital. He had no savings. His relatives were all in Russia. The prognosis was unfavorable.

CASE 123. A native of Italy. Age 18 years. A single man.

This patient landed at New York in 1904. The diagnosis was chronic pulmonary tuberculosis, with a history of 2 years existence. He had been unemployed 6 months and had no savings at the time of admission to the Hospital. His father was living in Italy. His brothers and a sister were living in this country. The prognosis was unfavorable.

CASE 124. A native of Ireland. Age 29 years. A single man.

This patient landed at New York in October, 1902. The diagnosis was alcoholism, of undetermined extent. He had been in Bellevue Hospital 3 weeks before. He had been out of work for 2 months prior to entering the Hospital. The only relative in this country was a married sister. The prognosis was unfavorable.

CASE 125. A native of Russia. Age 40 years. A married man.

This patient landed at New York in January, 1905. The diagnosis was gonorrheal polyarthritis, following infection 6 months before. He earned $20.00 a week, but had been unemployed 6 months and had no savings at the time of admission to the Hospital. He was transferred to a chronic hospital. His wife, a dressmaker, earned about $10.00 a week and supported 3 children. His mother was living in Europe. The prognosis was unfavorable.

CASE 126. A native of Austria. Age 26 years. A single man.

This patient landed at New York in August, 1904. He came to this City from San Francisco, where he had lived for 9 years, about 2 months prior to admission to the Hospital. The diagnosis was syphilis and gonorrheal infection, with a syphilitic history for 3 years and gonorrheal infection 4 months before. He had no savings at the time of admission to the Hospital and had no relatives in this country. The prognosis was unfavorable.

CASE 127. A native of Greece. Age 23 years. A single man.

This patient landed at New York in March, 1911, and went to Pennsylvania. He came to this City from Pennsylvania, where he had lived for 2 years and 3 months prior to admission to the Hospital. The diagnosis was chronic pulmonary tuberculosis, with a history of 8 months existence. He was transferred to a chronic hospital. He had no relatives in this country and no savings at the time of admission to the Hospital. The prognosis was unfavorable.

CASE 128. A native of Italy. Age 32 years. A widower.

This patient landed at New York in April, 1910, and went to Philadelphia. He came from Philadelphia to this City about 2 months prior to admission to the Hospital. The diagnosis was chronic pulmonary tuberculosis, with a history of 5 months of acute illness. He earned $15.00 a week, but at the time of admission to the Hospital he had no savings. He had no relatives in this country and had 2 children dependent upon him in Italy.

CASE 129. A native of Austria. Age 22 years. A single woman.

This patient landed at New York in October, 1907. The diagnosis was parturition. She had no relatives in this country. Her parents were living in Austria. At the time of admission to the Hospital she had no savings. The medical prognosis was favorable.

CASE 130. A native of Ireland. Age 37 years. A single woman.

This patient landed at New York in 1898. The diagnosis was chronic alcoholism, with an alcoholic history of undetermined extent. She had been out of work for 1 month prior to admission to the Hospital. She had no relatives in this country. The prognosis was unfavorable.

CASE 131. A native of Russia. Age 29 years. A married woman.

This patient landed at New York in May, 1905. The diagnosis was chronic pulmonary tuberculosis, with a history of 2½ years illness. She had previously been admitted to Bellevue. She had 2 children under the age of 5 years. Her husband, a rag dealer, did not pay for the medical treatment. The prognosis was unfavorable.

CASE 132. A native of Hungary. Age 34 years. A married man.

This patient landed at New York in May, 1903. The diagnosis was chronic gonorrhea, contracted in January, 1912. He had earned $12.00 a week, but had been out of work 1 week and had no savings at the time of admission to the Hospital. He did not know the whereabouts of his wife, and had no other relatives in this country. The prognosis was unfavorable.

CASE 133. A native of England. Age 26 years. A single man.

This patient was a seaman. The diagnosis was venereal trouble, with a history of infection of 2 years before. He was brought by an ambulance directly from the ship to the Hospital. He had no savings and the steamship company failed to pay for him. He had no relatives in this country. His mother was living in England. The prognosis was unfavorable.

CLASS I-4a. Aliens deportable (with consent) under the State Insanity Law.—From causes existing prior to landing.

CASE 1. A native of Italy. Age 36 years. A single woman.

This patient landed at New York in 1909. She was in the Hospital for psychopathic examination and was transferred as insane to a State Hospital. The diagnosis was general paresis, with causes existing prior to landing. The prognosis was unfavorable.

CASE 2. A native of Russia. Age 34 years. A single man.

This patient landed at New York in 1908. He was in the Hospital for psychopathic observation, with condition originating prior to landing in the United States. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 3. A native of Italy. Age 30 years. A married woman.

This patient landed at New York in 1908. She was suffering from general paresis, with condition originating prior to landing in the United States. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 4. A native of Russia. Age 30 years. A single man.

This patient landed at New York in 1908. This was a psychopathic case deported twice previously, and deported the third time after this admission when transferred as insane to a State hospital.

CASE 5. A native of Germany. Age 42 years. A married woman.

This patient landed at New York in 1908. She was a psychopathic patient with condition originating prior to landing and also suffering from pulmonary tuberculosis. She was an attempted suicide. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 6. A native of Russia. Age 20 years. A single woman.

This patient landed at New York in December, 1909. She was a psychopathic patient, with condition originating prior to landing in this country. The prognosis was unfavorable.

CASE 7. A native of Russia. Age 60 years. A widow.

This patient landed at New York in 1908. She was admitted to the psychopathic ward for observation. The diagnosis was senile dementia, with history of unbalanced mentality for a period of 5 years or more prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 8. A native of Austria. Age 35 years. A married man.

This patient landed at New York in 1908. He was admitted for psychopathic observation. The diagnosis was dementia præcox. The medical history recorded a statement that the patient had been insane for a period of 3½ years. One of his sisters was an inmate of a State hospital for insane and 2 of his cousins had committed suicide. He was returned to Austria at the expense of his relatives. The prognosis was unfavorable.

CASE 9. A native of Russia. Age 20 years. A single man.

This patient landed at New York in 1905. He was admitted as a psychopathic patient, with condition originating prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 10. A native of Russia. Age 21 years. A single man.

This patient landed at New York in 1902 and ever since had lived in Chicago. He was brought from the Grand Central Depot to the Hospital as a psychopathic patient, with condition originating prior to landing. He was transferred as insane to a State hospital and afterward removed at the expense of the State to Chicago. The prognosis was unfavorable.

CASE 11. A native of Italy. Age 18 years. A single man.

This patient landed at New York in 1908. He had been an imbecile prior to landing. He was deported to Italy by his relatives through the State.

CASE 12. A native of Ireland. Age 24 years. A married woman.

This patient landed at New York in 1908. She was admitted to the Hospital as a psychopathic patient, from causes originating prior to landing. She was transferred as insane to a State hospital and then deported by the State.

CASE 13. A native of Hungary. Age 14 years. A girl.

This patient landed at New York in 1908. She was admitted to the psychopathic ward for observation. The history showed that her condition originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 14. A native of Russia. Age 26 years. A married woman.

This patient landed at New York in 1908. She came from Chicago and was taken from the Grand Central Depot, on the same day, to the Hospital for psychopathic observation. The history showed that her condition originated prior to landing. She was to have been deported 4 months previously, but escaped. She was deported to her home abroad by friends.

CASE 15. A native of Italy. Age 17 years. A single man.

This patient landed at New York in 1908. He was admitted for psychopathic observation. The diagnosis was dementia præcox, from causes originating prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 16. A native of Russia. Age 23 years. A single man.

This patient landed at New York in August, 1908. He had been a resident of Jersey City since landing and was admitted to the Hospital for psychopathic observation. The diagnosis was dementia præcox, from causes existing prior to landing. The history contained a record of two attempts to commit suicide. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 17. A native of Mexico. Age 38 years. A single man.

This patient came to the United States via the Mexican border. He had been an inmate of an insane hospital at Washington, D. C., for the previous 6 months and had been taken from there by his brother, who intended to remove him to Mexico. The patient, however, refused to go. His brother said that he had been mentally irresponsible for 12 years. He was returned to Mexico by representatives in this country.

CASE 18. A native of Russia. Age 38 years. A single man.

This patient landed at New York in 1905. He had been only 3 days in this State. He had come from Massachusetts. He had been admitted for psychopathic observation and was transferred as insane to a State hospital. The history showed that his condition originated prior to landing. The prognosis was unfavorable.

CASE 19. A native of Russia. Age 27 years. A single man.

This patient landed at New York in 1908. He was admitted to the Hospital for psychopathic observation and transferred as insane to a State hospital. His history showed that his condition originated prior to landing. The prognosis was unfavorable.

CASE 20. A native of Italy. Age 28 years. A single man.

This patient landed at New York in 1911. He had been admitted to the psychopathic ward for observation. His history showed that his father had been insane. His condition was from causes existing prior to landing. He was transferred as insane to a State hospital. He had returned to Italy 2 years ago and came back to this country 3 months before admission to the Hospital with symptoms of this trouble. The prognosis was unfavorable.

CASE 21. A native of Turkey. Age 28 years. A single man.

This patient landed at New York in 1908. He came to New York from Montana the day before admission to the Hospital. An effort had previously been made to deport him from California, but the steamship company had refused to accept him. The history showed that his condition originated prior to landing and existed prior to coming to this State. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 22. A native of Russia. Age 30 years. A married woman.

This patient landed at New York in 1907. She was admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 23. A native of Ireland. Age 27 years. A single man.

This patient landed at New York in 1908. He had been a chronic alcoholic and was admitted to the psychopathic ward for observation. The diagnosis was dementia præcox. His father had been insane. His condition was due to inherited tendency and constitutionally inferior mentality, consequently originating prior to landing. He was discharged in the custody of the Tombs officials. The prognosis was unfavorable.

CASE 24. A native of Russia. Age 50 years. A married man.

This patient landed at New York in 1908. He had been admitted to the Hospital for psychopathic observation. His condition originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 25. A native of Germany. Age 48 years. A single woman.

This patient landed at New York in 1881. She was admitted to the Hospital for psychopathic observation. The history showed that her condition was constitutional and originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 26. A native of Hungary. Age 33 years. A single man.

This patient landed at New York November 4, 1907. He had come to New York from Ohio 3 weeks before admission to the Hospital for psychopathic observation. His history showed that he had been a chronic alcoholic and that his mental condition had originated prior to landing. He was discharged in the custody of the State officials.

CASE 27. A native of Russia. Age 54 years. A widow.

This patient landed at New York in 1908. She had been admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 28. A native of Russia. Age 73 years. A widow.

This patient landed at New York in 1906. She had been an inmate of a charitable institution ever since landing. She was admitted to the psychopathic ward for observation. Her history showed that the condition existed prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 29. A native of Turkey. Age 42 years. A married man.

This patient landed at New York in 1909. He had secondary syphilis, with a history of luetic infection of years' standing. His condition originated prior to landing. The prognosis was unfavorable.

CASE 30. A native of France. Age 33 years. A single woman.

This patient landed at New York in 1909. She had been admitted to the Hospital for psychopathic observation. Her history showed that the condition had originated prior to landing. The patient's mother had been insane. She, herself, had showed evidence of insanity for years. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 31. A native of Greece. Age 27 years. A single man.

This patient landed at New York January 4, 1907. He was admitted to the Hospital for psychopathic observation. His history showed that his condition had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 32. A native of Austria. Age 46 years. A single woman.

This patient landed at New York in 1905. She was admitted to the Hospital for psychopathic observation. Her history showed that the condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 33. A native of Russia. Age 16 years. A girl.

This patient landed at New York in 1908. She was admitted to the psychopathic ward for observation. The history showed that her condition had originated prior to landing. Her maternal aunt had been insane. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 34. A native of Russia. Age 40 years. A married man.

This patient landed at New York in 1908. The history showed that he had been an alcoholic and that his condition had originated prior to landing. He was admitted to the psychopathic ward for observation. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 35. A native of Hungary. Age 26 years. A single woman.

This patient landed at New York in 1902. She was admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing. She was removed from the Hospital by her relatives. The prognosis was unfavorable.

CASE 36. A native of Hungary. Age 24 years. A single woman.

This patient landed at New York in 1909. The history showed that her condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 37. A native of Italy. Age 23 years. A single man.

This patient landed at New York in 1905. He was admitted to the Hospital for psychopathic observation. The history showed that his condition had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 38. A native of Ireland. Age 27 years. A single man.

This patient landed at New York in 1908. This was the patient's second admission to the psychopathic ward at Bellevue. The diagnosis was dementia præcox. His history also recorded chronic alcoholism. He was transferred to a State hospital and deported at State expense.

CASE 39. A native of Russia. Age 40 years. A man.

This patient landed at New York in 1908. The history showed that his condition had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 40. A native of Russia. Age 35 years. A single man.

This patient landed at New York April 11, 1910. He was placed on a train for New York City by the police of a town in Massachusetts and was brought from Grand Central Depot to the psychopathic ward. The history showed that his condition had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 41. A native of Ireland. Age 30 years. A single woman.

This patient landed at New York in October, 1903. She was admitted to the alcoholic ward and transferred to the psychopathic ward for observation. The diagnosis was chronic alcoholism and dementia. The history showed that she was of a constitutionally inferior make-up and that her condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 42. A native of Canada. Age 52 years. A married man.

This patient landed at New York in 1906. He had been an inmate of an insane asylum in 1902. The diagnosis was dementia præcox (paranoid), which existed prior to landing. This patient was discharged as insane. The prognosis was unfavorable.

CASE 43. A native of Italy. Age 41 years. A single woman.

This patient landed at New York in 1909. She had been admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing. She was discharged in her own custody.

CASE 44. A native of Italy. Age 36 years. A married woman.

This patient landed in the United States in 1908. She had been admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 45. A native of Russia. Age 18 years. A single woman.

This patient landed at New York in 1905. She had been admitted to the Hospital for psychopathic observation. The diagnosis was dementia præcox, which had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 46. A native of France. Age 50 years. A widow.

This patient landed at New York in 1907. She had been admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 47. A native of British West Indies. Age 24 years. A widow.

This patient landed at New York in 1904. She came to this State in April, 1913. She had been admitted to the Hospital for psychopathic observation. The diagnosis was dementia præcox (paranoid), which originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 48. A native of Germany. Age 33 years. A single man.

This patient landed at New York in 1907. The history showed that his condition originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 49. A native of Italy. Age 22 years. A married woman.

This patient landed at New York December 14, 1909. She had been admitted to the Hospital for psychopathic observation. The history showed that her condition had originated prior to landing and that she had always been peculiar in her behavior. She had practically deserted her husband and 3 small children. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 50. A native of Russia. Age 27 years. A single man.

This patient landed at New York in 1907. He had been admitted to the Hospital for psychopathic observation. The history showed that his condition had originated prior to landing and that he had an advanced form of syphilis. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 51. A native of Austria. Age 25 years. A married woman.

This patient landed at New York in May, 1903. She had been admitted to the Hospital for psychopathic observation. The diagnosis was dementia præcox (paranoid), which had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 52. A native of Austria. Age 32 years. A married man.

This patient landed the second time on March 24, 1910. He had been deported by the Federal authorities in January, 1910. He had been admitted to the Hospital for psychopathic observation. The history showed that his condition had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CLASS I-4b. Aliens deportable (with consent) under the State Insanity Law.—From causes whose priority to landing is not certain.

CASE 1. A native of Austria. Age 22 years. A single man.

This patient landed at New York in 1907. He had been a chronic alcoholic and had been admitted to the Hospital for psychopathic observation. It was not established whether or not he had psychopathic conditions existing prior to landing. The prognosis was unfavorable.

CASE 2. A native of Italy. Age 42 years. A single man.

This patient landed at New York in 1905. He was admitted to the psychopathic ward for observation. The diagnosis was general paresis, with evidence of syphilis. His condition was probably due to causes existing prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 3. A native of Hungary. Age 36 years. A married man.

This patient landed in the United States in 1909. He was admitted to the Hospital for psychopathic observation and was transferred as insane to a State hospital. The history also portrayed alcoholism, but it was not established whether his mental condition originated prior to landing. The prognosis was unfavorable.

CASE 4. A native of Hungary. Age 44 years. A married man.

This patient landed in the United States in 1903. He was admitted to the Hospital for psychopathic observation and was transferred as insane to a State hospital. The history showed that he was an alcoholic, but it was not established whether his mental condition had originated prior to landing. The prognosis was unfavorable.

CASE 5. A native of Austria. Age 43 years. A widower.

This patient landed at New York in 1910. He was brought from a private hospital to the psychopathic ward for observation. The history showed that he had had an injury to his head 6 months prior to admission. It could not be determined whether any contributing factors to his mental condition had existed prior to landing. The prognosis was unfavorable.

CASE 6. A native of Ireland. Age 39 years. A single woman.

This patient landed in the United States in 1904. She was admitted to the Hospital for psychopathic observation and was transferred as insane to a State hospital. Her condition had probably originated prior to landing. The prognosis was unfavorable.

CASE 7. A native of Italy. Age 34 years. A widow.

This patient landed at New York in 1907. She had previously been admitted to Bellevue Hospital for psychopathic observation. She had a 3 years history of delusion. It was not determined whether her mental condition had originated prior to landing. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 8. A native of Russia. Age 25 years. A married man.

This patient landed at New York in 1908. He had been admitted to the psychopathic ward for observation. It was not determined whether his mental condition had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 9. A native of Austria. Age 24 years. A married man.

This patient landed at New York in 1905. He was admitted to the psychopathic ward for observation. He had been a chronic alcoholic for years. His history indicated that his condition probably had originated prior to landing. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 10. A native of Russia. Age 23 years. A single woman.

This patient landed at New York in 1908. She had been admitted to the psychopathic ward for observation. It could not be determined whether or not her mental condition had originated prior to landing. She was discharged in the custody of her mother. The prognosis was unfavorable.

CLASS I-4c. Aliens deportable (with consent) under the State Insanity Law.—From causes existing subsequent to landing.

CASE 1. A native of Russia. Age 29 years. A married woman, who was separated from her husband and had become a prostitute.

This patient landed at New York in 1907. She came to this State 2 days before admission to the Hospital. Her diagnosis could not be determined. She was removed to Connecticut by the State.

CASE 2. A native of Russia. Age 60 years. A widow.

This patient landed at New York in 1907. She had previously been admitted to Bellevue psychopathic ward. She was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 3. A native of Switzerland. Age 65 years. A married man.

This patient landed at New York 47 years ago. He had been settled in New Jersey and was brought from there on the day of admission to the Hospital. The diagnosis was senile psychosis, which had originated prior to his coming to New York State. He was transferred as insane to a State hospital. The prognosis was unfavorable.

CASE 4. A native of Austria. Age 39 years. A married man.

This patient landed at New York in 1901. He was a chronic alcoholic, with a history of injury to the head 1 year previous to admission. He was admitted to the psychopathic ward for observation. He was discharged in the custody of his wife. The prognosis was unfavorable.

CASE 5. A native of Russia. Age 29 years. A single man.

This patient landed in the United States in February, 1901. He had resided continuously in Chicago, Ill. He was taken to the psychopathic ward directly from the Grand Central Depot. The diagnosis was general paresis, which had existed prior to coming to New York State. This patient was transferred as insane to a State hospital. The prognosis was unfavorable.

2. ADMISSIONS TO CITY HOMES (ALMSHOUSES)

THE INVESTIGATION

BY

H. B. DINWIDDIE

SYNOPSIS

When the Counties of New York, Kings, Queens, and Richmond were merged into the City of New York the problem of municipal care for the dependent poor of the new City was placed under the administration of one department, the Department of Public Charities, which replaced the independent local authorities. Not only was the local administration of the public charitable relief thus affected, but, at a later period, some redistribution of the inmates of the County almshouses took place. When the Richmond County Almshouse, with the farm surrounding it, was set aside as a farm colony for the employment of the more able-bodied dependents in the almshouses of the City, the decrepit and mentally enfeebled inmates of this institution were transferred to other institutions more appropriate for their care. A steady stream of transferred dependents began to pour into this colony from the two other almshouses and grew to such proportions that the local function of this almshouse became obscured.

Not only were the three almshouses operated by one fund, appropriated by the Board of Estimate and Apportionment, and expended under the supervision of one administrative head, the Commissioner of Public Charities, but they became also interdependent to a considerable extent in providing accommodation for the dependent poor of the City.

For the examination of applicants for admissions to the almshouses there were established Bureaus of Dependent Adults as follows: one in the Borough of Manhattan for applicants from Manhattan and The Bronx; one in the Borough of Brooklyn for applicants from Brooklyn and Queens; and one in the Borough of Richmond for that borough. At these Bureaus the applicants that were not properly charges upon the City of New York were supposed to be sifted out.

A study was made of the admissions to the three almshouses in the City of New York, namely: the New York City Home for the Aged and Infirm, Manhattan Division; the New York City Home for the Aged and Infirm, Brooklyn Division; and New York City Farm Colony. This study included a general examination of the admissions to the three almshouses during the year 1911 and the first 6 months of the year 1912, with a detailed study of the admissions in 2 months of these years. It developed that, while the majority of the dependents appeared to have passed through the Bureaus of Dependent Adults, admissions had also been made to all three almshouses through other avenues. For example, dependents were found to have been admitted to the Manhattan Home through the Emergency and Relief Station of the Department of Public Charities, at the foot of East 70th Street, and by some other avenue that could not be ascertained. Also, the dependents were found to have been admitted in considerable numbers to the Brooklyn Home by transfer from Kings County Hospital and, apparently, also by subordinate officials in the Home itself; and at Farm Col-

ony some admissions were made by the order of the Superintendent of the Colony.

Permits were issued by the different Bureaus to be presented at the institutions by dependents as evidence of the authorization of their admission. In a small proportion of the admissions to the Manhattan Home these permits were lacking from the files at the Home for the 2 months for which the examination was made. In the case of 23 per cent. of the admissions to the Brooklyn Home in the month studied, instead of the permits from the Brooklyn Bureau of Dependent Adults, there were found in the files at the Home transfer permits from Kings County Hospital over the name of its Superintendent. Reference to the records at this Hospital showed that some of these dependents had not been recipients of acute hospital treatment, and that some did not even appear in the card file of their discharged patients. Instances of the use of this Home by dependents as a lodging house were also discovered. Such admissions were said to be at the discretion of the subordinate officials immediately over the male and female inmates of the Home. Permits for admission to Farm Colony were found to have been issued by all three Bureaus. The Manhattan Bureau, however, was said to have control over the transfers from the Brooklyn Home, although permits for these transfers were made out in the Brooklyn Bureau. Upon the books of Farm Colony the authority recorded for a number of admissions during the year July 1, 1911, to June 30, 1912, was merely, "By order of the Superintendent." There were 6 such admissions in 1 of the 2 months for which examination was made.

The Manhattan and Brooklyn Homes felt the pressure upon them of the heavy transfer of dependents from hospitals, and as the new dormitories were opened at Farm Colony transfers were made from these Homes to the Colony to fill the vacancies there and relieve the congestion at the Homes. In order to prevent a return of these congested conditions by these dependents leaving the Colony and receiving readmission to the Home from which they had been discharged, it was adopted as a policy of the Bureaus of Dependent Adults in Manhattan and in Brooklyn to forbid the readmission to the City Homes of any dependent who had been transferred to the Colony. This rule was incorporated in a letter written by the Second Deputy Commissioner of Charities, in charge of the Brooklyn office of the Department of Public Charities, under date of October 7, 1911, in which he stated that it had been brought to his attention that this policy was not being pursued, and ordered that no such dependents should be readmitted to the Brooklyn Home, but that all of them should be referred to the Manhattan Bureau. While there is no method of ascertaining what proportion of these dependents that applied to be readmitted to the two City Homes were refused such admission, a study of over 1,500 discharges of dependents from the two Homes showed that in the case of a large proportion of these the Bureaus exercised practically no control that hindered their reëntering the institutions from which they had been discharged for transfer to the Colony.

Not only was this general administration policy overridden at the volition of the dependent who preferred the Home to Farm Colony, but it would seem that the disciplinary methods which the Superintendent of the Colony had found it advisable to employ were rendered more or less ineffective. A number of instances were found of dependents who had been expelled from the Colony by the order of the Superintendent, yet seemed to have had no difficulty in securing immediate or early admission to the City

Homes from which they had been transferred. It is presumable that the effect of the disciplinary expulsion was lessened by the easy readmission to another institution.

As early as the year 1902 the Commissioner of Public Charities in office at that time set aside the institution then known as the Richmond County Almshouse under the new title of New York City Farm Colony, for occupation by the more able-bodied inmates of the almshouses who should, by manual labor, bring some return to the City for the cost of their maintenance. To insure an able-bodied population the mentally and physically incapable dependents at that time in the Colony were taken to other institutions, and individuals that seemed better fitted for useful labor upon the farm were selected and transferred to the Colony. The annual reports of the Department of Public Charities showed a steady yearly increase in the value of the crops raised by these dependents for several years after this change was made, and also showed a comparatively small proportion of paid employees to have been at the Colony. This basis of selection of inmates for the Colony has apparently been abandoned, for the records of that institution showed that in August, 1912, the crippled, paralytic, and the blind had been admitted there in considerable numbers, and that over one-third of the inmates there were over 70 years of age.

Although specific provision was made in the Poor Law of the State of New York for the keeping of detailed records of the dependents admitted to almshouses, and this law makes it mandatory upon the officers responsible for the care and relief of poor persons to send full information regarding the dependents with them to the almshouse to which they are to be admitted, an examination of the records of the Bureaus of Dependent Adults showed that they neither placed in their own files during the years 1911 and 1912 the information that the law seems to require, nor transmitted to the almshouses such information as was on the records of the Bureaus. Far more complete histories of the dependents were found at the Manhattan Home than at the Bureau of Dependent Adults through which they had been admitted. In the case of transfers from almshouse to almshouse the records seemed rarely to have accompanied the dependent, necessitating the taking of a new record each time.

As the Department of Public Charities during these years of 1911 and 1912 maintained no general file containing the names of public charges in municipal institutions, it is difficult to see how it would have been possible to prevent a dependent entering either of the Homes in violation of the rules of the Bureaus of Dependent Adults. It was also entirely possible that one institution or Bureau might adopt a certain policy toward an individual dependent based on information at hand while there might be contained in the records of another almshouse or Bureau information that would justify the pursuit of an entirely different course in handling the case. As a matter of fact, a good many of the dependents who were aliens were entered as such on the records of the almshouses, while the Bureaus had no such information recorded. As the details in the records called for by law (and for which blank forms were provided by the State Board of Charities) were not entered upon the records in many instances at Farm Colony, and these records were complete in only a very few instances at the Brooklyn Home, for the admissions in the months stated, it was impossible to determine just what proportion of the dependents admitted to these institutions were aliens or non-residents. Information regarding the naturalization of dependents of alien birth was omitted from a number of the rec-

ords of the dependents admitted in 2 months to Farm Colony, and from a large proportion of the records for the month studied at the Brooklyn Home.

An investigation was made of 833 admissions entered upon the records of dependents admitted to the Manhattan Home in the months of December, 1911, and May, 1912; to the Brooklyn Home in the month of May, 1912; and to Farm Colony in the months of December, 1911, and May, 1912. The investigation revealed that the addresses of dependents as recorded at the institutions could be classified as follows:

Residences of dependents just prior to admission	180, or 21.6%
Residences of dependents at some time before admission	38, " 4.6%
Addresses where dependents were not known	196, " 23.5%
Addresses of lodging houses	141, " 16.9%
Addresses that were not residential	48, " 5.8%
Addresses that were not sufficiently explicit for investigation	18, " 2.2%
Addresses that were outside of the City	7, " .8%
Dependents admitted without residential address	205, " 24.6%
Total	833, or 100.0%

Upon the records of some of the admissions in the same months at the same institutions there were 758 addresses of relatives and friends to be communicated with in case of necessity, which, after investigation, were classified as follows:

Residences of relatives or friends just prior to the admission of the dependents	370, or 48.8%
Residences of relatives or friends at some time before the admission	30, " 4.0%
Addresses where the relatives or friends were not known	173, " 22.8%
Addresses of lodging houses	28, " 3.7%
Addresses that were not residential	56, " 7.4%
Addresses that were not sufficiently explicit for investigation	35, " 4.6%
Addresses that were outside of the City	66, " 8.7%
Total	758, or 100.0%

The charter of the City of New York makes it mandatory upon the Commissioner of Public Charities to investigate the circumstances of every person admitted to the institutions under his charge, and also the near relatives of such a person. If practicable, this investigation is to be made before the admission of an applicant. A detailed study, including visits to the home addresses of the dependents and their relatives or friends, was made of the following admissions: male admissions to the Manhattan Home in December, 1911, amounting to 186; male admissions to the same Home in May, 1912, amounting to 253; all admissions to the Brooklyn Home in May, 1912, amounting to 241; all admissions to Farm Colony in the month of May, 1912, amounting to 98; and 90 of the 145 admissions to the Colony in December, 1911.

It was noticeable that an extremely small percentage of these 923 admissions were of Hebrews. The religion was not ascertained for 103 of these dependents, owing to the manner in which the records were kept. Of the remaining 820 cases, however, only 28 admissions, or 3.4 per cent., were of dependents of the Hebrew faith, while 282 of the admissions, or 34.4 per cent., were of Protestants, and 510 admissions, or 62.2 per cent., were of Catholics.

All of these 28 admissions of Hebrews were for dependents who were

either paralyzed, crippled, sick, or who had just been transferred from hospitals, or were held for investigation by the State Board of Charities for possible removal.

The investigators of the Committee were unable to obtain sufficient information to permit of the classification of 406 of the above admissions because of the following reasons:

The addresses found at the almshouses were insufficient in	107 Cases
The dependents were unknown at the addresses given in	219 "
The addresses given were too old in	19 "
Sufficiently complete histories could not be secured in	61 "
Total	406 Cases

In the remaining 462 cases, however, the information gathered seemed to justify their classification as follows:

Dependents who seemed to have had a legitimate claim upon the City's support	230, or 49.8%
Dependents who were aliens	125, " 27.0%
Dependents who did not have a legal settlement in New York City	17, " 3.7%
Dependents who had legally responsible relatives able to pay for their maintenance	34, " 7.4%
Dependents who were personally able to pay for their maintenance	9, " 2.0%
Dependents who had served in the U. S. Army or Navy, or who were widows of men who had served in the U. S. Army or Navy	7, " 1.5%
Dependents who had relatives or friends willing to support them in their homes	14, " 3.0%
Dependents who were able to work to earn their own support	11, " 2.4%
Dependents who were committed by magistrates for observation as to their sanity	7, " 1.5%
Dependents who had relatives not legally responsible but able to pay for their maintenance	8, " 1.7%
Total	462, or 100.0%

Not only did it appear from the above classification that the Bureaus of Dependent Adults failed to make investigation of the applicants for admission to the almshouses, but it was also evident from comparison of the history cards in the almshouses with those for the same dependents in the Bureaus that the Department was not making use of information contained in its own files. There was lacking in the Department that coordination between the records in the Bureaus and the records in the almshouses that would have made this information of use to the Bureaus, and would have served as a corrective to both records.

The expense for the maintenance of the above dependents was estimated by ascertaining the total days of stay of all of the dependents represented in the above classification from the records of the institutions, and obtaining from the Annual Reports of the Department of Public Charities the amount of the average per diem expense of the maintenance of each dependent for the last 5 years. This maintenance expense, as is understood, covered only the local cost of maintenance at the institution, and did not include the general administration expenses of the Department, corporate stock expenses, or any charges of a general nature.

These dependents were segregated into three groups as follows:

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.

Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

The dependents found to fall into Group I remained in the same almshouses into which they were admitted, during the months considered, for a period of 40,101 days, at a total estimated expense to the City of $13,330.93.

Group II.
Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

The dependents in Group II remained in the same almshouses to which they were admitted, in the months considered, for a period of 6,430 days, at a total estimated expense to the City of $1,981.89.

Group III.
Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

The dependents in Group III remained in the same institutions to which they were admitted, in the months considered, for a period of 4,905 days, at an estimated expense to the City of $1,582.27. The total number of days stay of all these dependents, as stated, was 51,436 days, at an estimated expense to the City for their maintenance of $16,895.09. (Table XLIX.)

The above estimates, however, cover only the 462 admissions for which sufficient information could be gathered to permit of their classification. Accepting the proportions of the three groups to the total of the cases classified for the entire 868 admissions considered (Table L) the estimated expense of these dependents falling into the same groups would have been as follows:

Group I	$30,832.25
Group II	3,132.40
Group III	3,199.79
Total	$37,164.44

Although under the Poor Law of the State of New York all men who have served in the U. S. Army or Navy and the widows or children of such men are excluded from the almshouses, it was found that a number of these were admitted. In 1 case the fact that the dependent admitted had been in such service was entered upon his history card at the Bureau of Dependent Adults.

The State Charities Law of the State of New York empowers the State Board of Charities to visit any institution subject to its supervision to ascertain if any of the dependents there are non-residents or alien poor, and to remove such dependents to the state or country from which they may have come. It was found that of the dependents admitted to the three almshouses in the months studied, 30 per cent. were alien or non-resident poor, and that only about 15 per cent. of these had been removed from these institutions by the State Board of Charities. The deficiency of the records in the Bureaus of Dependent Adults and in the almshouses made

it impossible to ascertain the total number of aliens and non-residents represented in the admissions to the almshouses in these months. It was also found that the Bureaus did not call the attention of the State Board of Charities to the presence of the majority of these aliens and non-residents in these institutions.

Not only was the Department of Public Charities found to have institutions more or less isolated that might naturally be supposed would be coördinated in coping with their common problem, but it was not found to be seeking the coöperation of the private social agencies of the community in handling the adult poor. The practice that is understood to be followed by the Bureau of Dependent Children of furnishing private charitable societies with the names of all children for whose maintenance at public expense applications had been made at this Bureau did not seem to obtain in the Bureaus of Dependent Adults, except in connection with applications made for admission to the cottages at Farm Colony. The opportunity afforded of coöperating in the constructive and preventive work of these agencies does not seem to have been sought by the Department of Public Charities, with the possible exception in the case of the dependents just mentioned. Information was found to be contained in the records of the almshouses that had been obtained upon the different admissions of the same dependent which bore upon the legality or propriety of the admission of dependents, but little, if any, effort seemed to have been made to have the Bureaus of Dependent Adults avail themselves of this information. Many of the dependents admitted in the months studied had previously been inmates of municipal institutions, but the social data on their records seemed to have been largely, if not entirely, unused by the Bureaus.

The Superintendents of the Bureaus of Dependent Adults seemed to have approved or disapproved very few of the total admissions in the months examined. Except in the Manhattan Bureau, for 1 of these 2 months practically nothing worthy of consideration was found to have been done in this respect. Less than 37 per cent. of these Manhattan admissions in this month seemed to have been approved or disapproved, and about one-third of this 37 per cent. seemed to have been passed upon only by the Examiners of Charitable Institutions. The Superintendent in the Brooklyn Bureau seemed to have no supervision or knowledge concerning the fitness of each dependent for admission.

Investigations were not found to have been made by the Examiners of Charitable Institutions of any consequence, except for the Manhattan Bureau, in 1 of the 2 months studied, and then only for less than 20 per cent. of the admissions in the month. In some of these investigations addresses on the records of the Department were not visited; information gathered by the Committee's investigators was not obtained; and a number of the recommendations based on these investigations and on the histories taken in the Bureau seemed not justified in the light of the facts obtained by the Committee's investigators.

CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION

During the year 1911 the total admissions of dependents to this Home was 4,134. Of these, as may be seen by reference to Table I, page 291, 647, or 15.6 per cent. of the total, were transfers from the municipal hospitals in this Department and in the Department of Bellevue and Allied Hospitals, with 5 transferred direct from Lebanon Hospital. The remainder of the admissions came as follows: 3,464 from the Bureau of Dependent Adults, Manhattan; 19 from the Work House, Blackwell's Island; and 4 from New York City Farm Colony.

During the first 6 months of 1912 there were 1,944 dependents admitted to this Home (Table II). Of these, 448, or 23.5 per cent. of the total, were admitted by transfer from the municipal hospitals; 1,482 of the remainder were admitted through the Manhattan Bureau; 9 were transferred from the Work House, Blackwell's Island; and 5 were transferred from Farm Colony.

Causes of Dependence

Beginning with January 1, 1912, the causes of dependence of those admitted to this Home have been entered in the admission book of the institution. These are said to have been gathered from the statements of the dependents upon admission. A study of these causes of dependence showed that 781 of the dependents, or 40.2 per cent., became such because of lack of employment; 815, or 42 per cent., through sickness; 335, or 17.2 per cent., through age or infirmity; 9, or 0.4 per cent., were blind; 2, or 0.1 per cent., were lost; 1 was an alcoholic; and the cause of 1 case was unknown. (Table III.)

Avenues of Admission

In order to ascertain the conditions governing the admission of dependents and the character of those admitted, a study was made of the total number of male admissions to this Home during the month of December, 1911, numbering 186 admissions, and during the month of May, 1912, numbering 253.

These dependents were found to have been admitted through the following agencies:

(a) Manhattan Bureau of Dependent Adults, of the Department of Public Charities, directly.

(b) The Examining Physician of the Department at the foot of East 26th Street.

(c) The Emergency and Relief Station of the Department (otherwise known as the Reception Hospital), at the foot of East 70th Street.

(d) Transfer from City and Metropolitan Hospitals, Blackwell's Island.

(e) Transfer from Harlem Hospital, of the Department of Bellevue and Allied Hospitals.

(f) Transfer from New York City Farm Colony.

(g) Transfer (in 1 case, it was said) from the list of employees to the register of dependents.

(h) A channel not ascertained.

Authority for Admissions

The authority for every admission to the almshouses is supposed to emanate from the Superintendents of the Bureaus of Dependent Adults. A portion of these cases are referred to the Examining Physician for medical diagnosis. Transfers from City and Metropolitan Hospitals must have permits from the Superintendents of the Bureaus of Dependent Adults, but the opinion of the discharging physicians at the Hospitals upon the propriety of the transfer is accepted as adequate. Transfers were allowed to be made from Harlem Hospital to the Neurological Hospital in connection with this Home by way of the Reception Hospital after consent had been obtained from the Superintendent of the Bureau by telephone. The Superintendent of the Bureau did not know of the other cases that were admitted through this Reception Hospital.

For the male admissions to this Home during December, 1911, there were found 165 permits, or 88 per cent. of the total number of male dependents, with the name of the Superintendent of the Bureau stamped or written upon them, and 15 permits from the Superintendent of the Bureau for the examination of dependents by the Examining Physician at the foot of East 26th Street, countersigned with a stamp by this physician, for admission to the Home. This would make 180 dependents, or 96 per cent. of the total, admitted directly or indirectly over the name of the Superintendent of the Bureau. There was also 1 permit from the Examining Physician's office not countersigned.

Five of the remaining admissions during this month were not recorded in the Bureau, but were made as follows: 2 dependents were admitted by transfer from Harlem Hospital, over the name of a doctor at that institution; 1 was admitted from the Emergency and Relief Station, otherwise known as Reception Hospital, over the signature of an interne connected with Metropolitan Hospital; and in the case of 2 others the channel of admission and the authority therefor could not be ascertained. (Table IV.)

For the male admissions during the month of May, 1912, there were found 142 permits bearing the name of the Superintendent of the Bureau alone upon them, and 101 bearing also the name of the Examining Physician. Thus, 243 of the total were admitted directly or indirectly over the name of the Superintendent of the Bureau of Dependent Adults.

There were found the following cases for this month without permits from the Bureau: 4 transfers from Harlem Hospital, over the name of a doctor there; 4 admissions through the Emergency and Relief Station at 70th Street, over the name of an interne or a doctor on Blackwell's Island; 1 admission from Farm Colony, over the name of its Superintendent; and 1 dependent who was said to have been transferred from the list of employees to the register of the dependents. (Table V.)

Although permission was supposed to have been asked by telephone of the Bureau for the above 4 transfers from Harlem Hospital in these 2 months, record could be found of only 1 of them at the Bureau. No record whatever was found at the Bureau for the 4 cases admitted by different doctors through the Reception Hospital. One of these cases was said by a relative to have been sent by a private physician in the City through the Emergency and Relief Station; another was an individual of some personal means whose treatment was afterward paid for in another institution; a

third had been a paying patient in a private institution for a long time prior to this admission; and the remaining case was that of an alien. (Table VI.)

In the case of the dependent referred to above as having been transferred from Farm Colony to the Home without a permit, there could be found no record of any kind at the Bureau of Dependent Adults. The dependent said to have been transferred from the position of employee to a place among the dependents was not found to be listed among the employees of the institution on the Civil List, covering this period, compiled at the institution and published by the *City Record*. According to the records of this Home this was his 19th admission as a dependent at this one institution. One of the dependents admitted in the month of December by a channel not ascertained was found to have been transferred twice previously from this Home to Farm Colony. This readmission, for which no authority could be ascertained, was in violation of a rule of the Bureau of Dependent Adults.

According to the records, 2 of these dependents admitted during December and 3 during May were admitted to this Home the day preceding the issuance of the permit.

Effort was made at the Bureau to discover what records existed there of the permits for these dependents. Nothing could be learned in this regard for the month of December, 1911, as no stubs for such permits could be found, but for the month of May, 1912, there were found 134 permit stubs corresponding to 134 of the 141 permits at the Home for this month bearing the name of the Superintendent. Permit stubs could not be located for any of the remainder of the male admissions for this month.

Control of Admissions

In violation of what was said to be the rule of the Bureau of Dependent Adults that no dependent who had been transferred to Farm Colony from this Home, or had been discharged from there for refusing such transfer, should be readmitted to any other institution than Farm Colony, it was discovered that of the total of 554 dependents discharged for transfer to the Colony from January 1, 1910, to June 30, 1912, 103 had been readmitted to this Home (Summary I on page 294 and Table VII). Practically all of these 103 were readmitted through the Bureau, and less than 13 per cent. of them were sent to Farm Colony again at the end of this first stay after readmission (Table VIII). A number of these came back and forth to the Home, through the Bureau, as many as half a dozen times without being returned to the Colony (List 1 on page 301). Not only was this true of these dependents after their first discharge for transfer to Farm Colony, but it was also true of the same individuals in a limited number of cases after their second and third discharges for transfer to the Colony.

It would appear that the disciplinary methods that the Superintendent of Farm Colony had found it advisable to employ were by this means made more or less ineffective, for of the first 103 admissions of such transfers, 7 had left the Colony by order of the Superintendent, and 46 were recorded upon the books of the Colony as having absconded from there; that is, having left the institution without receiving discharge through the Superintendent (Table VIII). Six were found to have been readmitted to the Home while absent from the Colony on a pass, and were recorded upon the books of the Colony as having terminated their stay there by overstaying their passes for a leave of absence from the institution. All of these dependents read-

mitted to the Home after their second discharge for transfer from there to the Colony had absconded from the Colony, and the 1 who was readmitted to the Home after his third transfer to the Colony had been expelled from the Colony by order of the Superintendent.

In all that has been said above regarding the readmissions to this Home of those transferred to Farm Colony, it must be borne in mind that only those readmissions were taken into account where the inmate had given the same name as upon his previous admission. No provision existed, so far as is known, for the detection of a readmission of a person who entered under an alias, and there is no means of computing what the actual number of readmissions of these dependents to this institution really was. The number of entries of these same dependents to the various other municipal institutions is also unknown.

As these dependents are transferred to Farm Colony to fill vacancies at that institution and to relieve congestion at this Home, the policy of the Department has been interfered with by their readmission to the institution from which they were transferred, and they contribute toward a return of the congestion which their transfer was designed to relieve. Although their disposition in leaving the Home for the transfer was recorded at this Home, and in the year 1912 supposedly at the Bureau of Dependent Adults also, so that in all of the 108 readmissions shown in Table VII the violation of the rule of the Bureau could have been detected, these dependents themselves, rather than those in authority over the institutions, seem to have had the power to choose where they would be public charges.

The system of records of dependents at the Manhattan Bureau did not provide for the prevention of this disregard of the rule of the Bureau. There was no general index file for the names of dependents admitted to almshouses, but the cards for the dependents admitted to the Manhattan Home and Farm Colony were kept separately, and further divided into two classes under each institution, those remaining in the institution being in one class, and those who had left or who had died being in the other. But even these index files had been kept in this form only for the year 1912, and they were by no means complete. Practically no reference record existed at the Bureau of dependents admitted to almshouses prior to 1912.

In the study of all the male admissions to this Home in the month of May, 1912, further knowledge was gained regarding the handling of the readmissions after transfer to Farm Colony. Of 253 such admissions in May, 20 were readmissions of these transfers. In the case of 8 of these, history records were taken and reviewed by either the Superintendent of the Bureau of Dependent Adults or by one of his Examiners of Charitable Institutions, and 7 of these 8 were approved to be admitted as dependents in this Home. No evidence could be discovered of any effort made at the Bureau to look up the previous histories of these inmates or even to learn whether they had ever before been in Farm Colony or any other institution.

History Records

For the year 1911 no record file of histories with financial and social data was kept at the Bureau of Dependent Adults for the inmates admitted to this Home. A few details regarding the dependents were provided for on the permit for admission to the Home; such as nativity, age, occupation, residence in City and country; but little, if any, effort was

made to obtain statements regarding the financial ability or inability of the applicants and of their relatives to relieve the City of the cost of their maintenance.

During 1912, however, effort is said to have been made to secure a history record at the Bureau of Dependent Adults for every applicant admitted to this institution. For the 253 males admitted during the month of May, 1912, there were found 217 history cards in the file at the Bureau. For the remaining 36 cases 25 stubs of permits were found at the Bureau, but no history cards. The remaining 11 cases without histories were as follows: 1 for whom an admission permit was signed by the Examining Physician; 2 for whom there were permits from the Superintendent of the Bureau of Dependent Adults, but for whom there was no permit stub at the Bureau; 3 transfers from Harlem Hospital; 4 admissions through the Reception Hospital on 70th Street; 1 admission on the order of the Superintendent of Farm Colony. (Tables IX and X.)

The entries made upon the history cards indicate that the histories of these inmates were reviewed by the Superintendent of the Bureau or one of his Examiners in only 101 of these May cases. In less than one-half of these 101 cases does any actual investigation seem to have been made outside of the office. In other words, of these 253 admissions in May, less than 86 per cent. were found to have had history cards made out for them; less than 42 per cent. appear to have been reviewed by the Superintendent of the Bureau, or an Examiner; and less than 20 per cent. appear to have had the history taken in the office confirmed or corrected by investigation. (Table X.)

Of these May cases, 103, or over 40 per cent., according to their statements on record at this Home, had previously been dependents in one or more of the municipal hospitals or almshouses, yet no reference to the previous histories of the same dependents was discovered on the history cards at the Bureau for May, 1912, and little effort to look up previous information was discernible.

The system of records kept at this Home regarding the dependents, while not containing detailed information about the financial ability of the dependents and their relatives, was the most complete in the three almshouses in the City of New York. Considerable effort had evidently been made to look up previous admissions of dependents and to connect them with the most recent one. This institution also kept a daily admission book and a daily discharge book. It lacked, however, a card census of inmates to show their location in the Home. The detailed histories of the dependents are kept in a State history book, required by the State Board of Charities in conformity with the law, and the records of the various admissions of the dependents are entered upon the forms in this history book.

The addresses on record at this Home of the residences of the dependents, and their relatives or friends who were to be communicated with in case of necessity, did not seem to be up to date. In a considerable number of cases in which the dependents had been in the institution a number of times the residence addresses given on some earlier admission remained unchanged, although the dependent might not have resided there for a number of years. An analysis of 166 records at this Home of dependents admitted during December, 1911, was made after the Committee's investigators had attempted to gather information regarding them, and only 20, or 12 per cent., of the addresses entered upon these records as the residences of the

dependents were found to have been their residences just prior to their admission at this time to the Home; 3, or 1.8 per cent., were addresses which the dependents had left a considerable time before their admission; while 35, or 21 per cent., were addresses where the dependents were not known. A considerable proportion of the addresses, 49, or 29.5 per cent., were lodging house addresses, and, therefore, of little value. In 9 cases, or 5.5 per cent., the addresses given were false as residence addresses; 3, or 1.8 per cent., were addresses outside of New York City; and the addresses for 4, or 2.4 per cent., of these cases were not sufficiently explicit for a visit. Among these 166 records were 43, or 26 per cent., upon which no residential address of the dependents were entered. (Table XI.)

A similar study of 161 addresses entered upon the records of dependents admitted to this Home in the same month shows that only 65, or 40.4 per cent., of the addresses given as the residences of friends and relatives were in fact the places of abode of these dependents just prior to their admission. At 9, or 5.6 per cent., of the addresses the friends had not lived for a considerable time previous to these admissions; and they were unknown at 40, or 24.8 per cent., of the places given as their residences. In 21, or 13 per cent., of the cases the addresses were outside of New York City; 12, or 7.5 per cent., of the addresses were visited and found not to be residential; 8, or 5 per cent., were lodging houses; and 6, or 3.7 per cent., of the addresses were not sufficiently definite to permit of a visit being made (Table XII). Also, during this month 35 of the 186 males admitted, or 19 per cent., entered the Home without giving the name and residence of any friend or relative.

On investigation by the Committee at addresses given on the records at the institution of 231 dependents admitted in May, 1912, as the residences of inmates, only 62, or 26.9 per cent., were found to have been the actual addresses of the dependents just prior to their admission. In the case of approximately the same number, 60 addresses, or 26 per cent. of the total, the dependents were not even known at the addresses. In addition to these, 55, or 23.9 per cent. of the total, were lodging house addresses, which, on account of the meager information obtainable about the lodgers at such places, are of practically no value. Thirty-six, or 15.6 per cent., of these 231 dependents were allowed to enter the institution without supplying any residence address; 10, or 4.3 per cent., were found to have given false addresses, such as would correspond to vacant lots, etc.; at 4, or 1.7 per cent., addresses the dependent had lived at a considerable time before this admission to the institution; addresses in 3, or 1.2 per cent., cases were insufficient for investigation; and 1, or 0.4 per cent., was outside of New York City. (Table XIII.)

Upon the records of the same dependents, admitted during this month of May, there were 246 addresses of their relatives or friends, which, after investigation, were analyzed as follows: 137, or 55.6 per cent., were found to have been the actual residences of relatives or friends of dependents; 50, or 20.2 per cent., were addresses where these relatives or friends were not known; 16, or 6.5 per cent., of the addresses were not residential; 9, or 3.6 per cent., were found to be addresses where the relatives or friends had lived at a considerable time before the admission of the dependents; and 12, or 4.8 per cent. of the total, were lodging house addresses. Of the balance of the 246 addresses, 7, or, 2.8 per cent., were insufficient for investigation and 15, or 6.5 per cent., were outside of the city (Table XIV). Also, 26 dependents, or 10 per cent. of the total males

admitted in this month, came into the institution without supplying the name and residence of any relative or friend to be communicated with in case of necessity.

Because of inability to secure the information desired from the addresses given on the records it became necessary for a number of dependents to be interviewed at the Home. It was noticed after this that in the case of some of these dependents new addresses were placed upon the records of the institution.

Character of Dependents

Section 663 of the Charter of the City of New York reads in part as follows:

> It shall be the duty of the Commissioner of Public Charities to investigate the circumstances of every person admitted to an institution under his charge and of the near relatives of such person. Such investigation shall be made, when practicable, before the admission of such person, and the results of the investigation shall be placed on file and preserved with the records of the department. . . .

All of the male admissions to this Home in the month of December, 1911, amounting to 186, and in the month of May, 1912, amounting to 253, were taken up for investigation, to determine, if practicable, the legality or the propriety of their dependence upon the City.

For 99, or 53.5 per cent., of the December admissions, sufficient information could not be gathered by the Committee's investigators to determine whether or not these were properly dependent. The reasons for this inability were as follows:

The addresses found at the Home were insufficient in	37 Cases
The dependents were unknown at the addresses given in	40 "
The addresses given were too old in	3 "
Sufficiently complete histories could not be secured in	19 "
Total	99 Cases

(a) Classification of Dependents

For the remaining 87 male admissions in this month, however, sufficient information was secured to enable their classification as follows:

Dependents who seemed to have had a legitimate claim upon the City's support	29, or 33.3%
Dependents who were aliens	38, " 43.6%
Dependents who did not have a legal settlement in New York City	12, " 13.8%
Dependents who had legally responsible relatives able to pay for their maintenance	2, " 2.3%
Dependents who were personally able to pay for their maintenance	2, " 2.3%
Dependents who had served in the U. S. Army or Navy	2, " 2.3%
Dependents who had relatives willing to support them in their own homes	1, " 1.2%
Dependents who were able to work to earn their own support	1, " 1.2%
Total	87, or 100.0%

(b) Estimate of Expense

An estimate of the expense to the City of maintaining these 87 dependents was made. The history books of the institution were searched for all the entries of these same dependents under the same names. The number of days of stay for each admission was then ascertained and the sum of the days for all the admissions was computed from this. The stay

of those dependents who were in the institution at the time of this search was counted only to the day on which the search was made. To arrive at the per capita per diem expense of each of these dependents the per capita per diem expense given by the Department in its Annual Reports for the last 5 years for this institution was taken, and the average for this period was used as the multiplier in calculating at what expense these dependents had been maintained for these days. As a matter of fact, as it is understood, this per capita per diem expense appearing in the Annual Reports merely covers the maintenance expense of the dependents at the institution and does not include any portion of the general administration expense of the Department, corporate stock expense, transportation expense, or other expense of a general nature. It is apparent, therefore, that the figures given in the following estimate only partially represent the actual expense to the City for the maintenance of these particular dependents.

These 87 dependents were segregated into three groups as follows:

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.

Dependents who were personally able to pay for their maintenance.

Dependents who were aliens.

Dependents who were non-residents of the City.

The dependents in Group I remained in this Home, after their various admissions, 17,794 days, at an estimated expense to the City of $5,363.11.

Group II.

Dependents who had served in the U. S. Army or Navy.

Dependents who were wives or children of men who had served in the U. S. Army or Navy.

The dependents in Group II remained in this Home a total of 782 days, at an estimated expense for maintenance of $235.69.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.

Dependents who had relatives or friends willing to support them in their own homes.

Dependents who were able to work to earn their own support.

The dependents in Group III remained in this Home 340 days, at an estimated expense of $102.48.

This would make a total estimated expense to the City for the maintenance of the dependents in these three groups of $5,701.28. (Table XVI.)

The above figures, however, apply only to those 87 cases in which it was possible to gather sufficient information for the classification of the dependents. Accepting the proportions of the various groups to the total of the 87 cases classified for the 186 admissions during this month, the estimated cost of the dependents would have been as follows:

Group I	$10,726.22
Group II	471.38
Group III	204.96
Total	$11,402.56

The investigation of the 253 admissions of males in May enabled the classification of a larger proportion of the dependents admitted in this month

than of those admitted in December. However, 87, or 34.3 per cent., of the admissions in May could not be classified because sufficient information could not be gathered, for the following reasons:

The addresses found at the Home were insufficient in	24 Cases
The dependents were unknown at the addresses given in	43 "
The addresses given were too old in	1 Case
Sufficiently complete histories could not be secured in	19 Cases
Total	87 Cases

(aa) Classification of Dependents

For the remaining 166 admissions of males for this month, however, sufficient information was secured to enable their classification as follows:

Dependents who seemed to have had a legitimate claim upon the City's support	86, or 51.8%
Dependents who were aliens	50, " 30.2%
Dependents who did not have a legal settlement in New York City	4, " 2.4%
Dependents who had legally responsible relatives able to pay for their maintenance	11, " 6.6%
Dependents who were personally able to pay for their maintenance	2, " 1.2%
Dependents who had served in the U. S. Army or Navy	3, " 1.8%
Dependents who were able to work to earn their own support	4, " 2.4%
Dependents who had relatives willing to support them in their own homes	2, " 1.2%
Dependents who had relatives not legally responsible but able to pay for their maintenance	4, " 2.4%
Total	166, or 100.0%

(bb) Estimate of Expense

These dependents were divided into three groups, constituted as those in December. The dependents in Group I remained in the Home an aggregate of 12,587 days, at a cost, computed similarly to that in December, of $3,793.72. The dependents in Group II remained in the Home an aggregate of 5,242 days, at a cost of $1,579.94. The dependents in Group III remained in the Home an aggregate of 1,590 days, at a cost of $485.52, aggregating for the total cost of the three groups, $5,859.18.

Accepting, as was done for the month of December, the proportions of the various groups to the total cases classified for the 253 admissions during May, the estimated cost of these dependents would have been as follows:

Group I	$5,774.30
Group II	2,404.78
Group III	739.00
Total	$8,918.08

(c) United States Soldiers and Their Families

Section 80 of Article 6 of the Poor Law of the State of New York reads in part as follows:

> No poor or indigent soldier, sailor or marine who has served in the military or naval service of the United States, nor his family, nor the families of any who may be deceased, shall be sent to any almshouse, but shall be relieved and provided for at their homes in the city or town where they may reside, so far as practicable, provided such soldier, sailor, or marine, or the families of those deceased, are, and have been, residents of the State for one year. . . .

In spite of this Act excluding from the almshouses all who have served in the Army and Navy of the United States, 2 soldiers, as shown in the "Classification of Dependents," were admitted in the month of December to this institution, where it appears from the record that this was the eighth admission at this Home for 1 of them. During the month of May there were 2 admitted who had served in the U. S. Army, and 1 who had served in the U. S. Navy. One of these was admitted to the institution despite the entry upon the record at the Bureau of Dependent Adults for this admission of the fact that he was a soldier. The records showed that this was the sixth admission for another of these dependents at this institution.

(d) Removal of Aliens and Non-Residents

Section 17 of Article 2 of the State Charities Law reads in part as follows:

> The State Board of Charities, and any of its members or officers, may, at any time, visit and inspect any institution subject to its supervision to ascertain if any inmates supported therein at a state, county or municipal expense are state charges, non-residents or alien poor; and it may cause to be removed to the state or country from which he came any such non-resident or alien poor found in any such institution.

During the month of December, 1911, there were 38 aliens and 12 non-residents admitted to this Home; 31, or 86.9 per cent., of these aliens appeared on the records as such, and 10, or 83.3 per cent., of the non-residents appeared on the books at the Home as non-residents of New York State.

In the Bureau of Dependent Adults a card file is kept of all alleged aliens or non-residents reported to the State Board of Charities for examination and removal in accordance with the powers of the Board set forth above. From this file it appeared that only 6 of the aliens and 8 of the non-residents admitted in this month were reported to the State Board of Charities by the Bureau. Three of the 6 aliens were removed by the Board, according to their monthly reports of removals, and 1 was removed by the Federal Government. It would appear from these same monthly reports that the State Board of Charities removed 5 more of these 38 aliens, whose names are not in the file at the Bureau of Dependent Adults as having been reported to the State Board of Charities in connection with their admission to this institution. Of the 8 non-residents reported by the Bureau to the Board, only 4 were removed by the State Board of Charities, according to their report. But 3 more of the 12 non-residents admitted to this Home during this month were reported by the Board as removed, although they do not appear in the Bureau of Dependent Adults' file as having been reported to the Board for removal in connection with their admission to this institution.

During the month of May 50 aliens and 4 non-residents were admitted to this Home, all of whom appeared as aliens and non-residents on the Home records. Only 10 of the aliens seemed to have been reported to the State Board of Charities and none of the non-residents. The State Board of Charities' monthly reports show the removal of only 4 of these aliens. One alien was removed by the Government for whom there appears no record of report by the Bureau of Dependent Adults to the State Board in connection with this admission, and another non-resident was removed by the State Board for whom there appeared no record in the file of cases reported to the State Board at the Bureau of Dependent Adults.

The registers of this Home were examined to learn whether these aliens had been in this Home because of need of medical treatment. From these books, of the 38 aliens and 12 non-residents admitted in December, 1911, only 4 aliens and 3 non-residents were found to have been in the hospital wards in connection with this Home, and of the 50 aliens and 4 non-residents admitted during May, 1912, only 5 aliens and 2 non-residents were found to have been in these wards.

(e) Comparison of Findings

The records of the Bureau of Dependent Adults showed that a number of the cases investigated by the Committee's field workers had also been investigated by the Examiners of Charitable Institutions, under the Superintendent of the Bureau. These cases were investigated for the month of May, 1912, only, little or no attempt having been made by the Bureau to investigate the admissions to this Home during the month of December, 1911. A comparison of some of these cases follows, under the Committee's case numbers instead of under the names of the dependents.

Case 24. The Committee's investigator learned that this inmate owned a small drug store and had been receiving treatment from private physicians after discharge from this Home. Also, that he had a son earning about $35.00 a week. The report of the Examiner of Charitable Institutions of the Department also showed this man to have been the owner of a drug store and considered by the clerk in charge as being able to pay. The finding of the Examiner was recorded as "N.F.," interpreted as "Not found at address given." Another entry upon the history of this case was "Not approved," interpreted to mean that the dependence of this individual upon the City was not approved. There was no record upon it of a visit to the address of the friend from whom the Committee's investigator obtained information. This case was, however, finally approved, according to the entry made upon the record. This dependent remained 43 days in the institution.

Case 50. The Committee's investigator was informed by the patient's mother that his brother was proprietor of an automobile business. There was no record of this fact upon the history obtained by the Examiner of the Bureau, and the case was approved without evidence of any effort to communicate with the brother.

Case 55. This dependent's wife said that he was able-bodied and went to this Home because she refused to allow the children to support him in idleness. He was working at the time of the investigator's visit, contributing $7.00 a week toward the family's expenses. There were 3 children in the family employed and 1 temporarily out of employment. The Home records showed that this dependent was an alien. The Examiner of the Department reported that the 3 children were employed and that the family was considered able to pay. This case was marked approved for dependence in the City Home. No evidence could be discovered that the State Board of Charities was requested to make an examination of this dependent as a possible subject for deportation.

Case 56. The Committee's investigator and the Examiner of the Department of Charities were alike unable to gather information regarding the dependent or his friend at the address given. The records of this Home, however, showed that this dependent was an alien, and that no evidence could be discovered that the State Board of Charities was requested to make an examination of him as a possible subject for deportation. This dependent was 26 days in the institution.

Case 70. The Committee's investigator interviewed the dependent at the address given, where he was living with a daughter and 2 sons, both of whom were employed. The same information was gathered as by the Examiner of the Department, to whom the sons claimed they were unable to pay. At the time of the visit of the Committee's investigator the family was supporting the father at home, but 1 son was working only about 3 or 4 days a week. The Bureau record is to the effect that this man was a citizen, whereas upon the Home record for this, his sole admission, it was stated that he was not a citizen. This statement was also made to the Committee's investigator by the dependent. The dependent remained 83 days in the institution.

Case 74. The Committee's investigator learned from 1 of the daughters whose address was given on the Home records the addresses of the dependent's 2 sons. The daughter said that she or her brothers would have been glad to support their father in any one of their homes. An Examiner of the Department of Public Charities reported that the children could not be located, but that the janitor at the address visited had reported that they were well-to-do. The investigation card was turned in at the Bureau for another Examiner to call upon the daughter, but was filed as "Not found." This dependent remained 96 days and died in the institution.

Case 79. The brother-in-law's address (obtained at this Home) was visited by the Committee's investigator, and his wife made the statement that this inmate had a bank account of $200, and apparently had had a considerable amount of money. No action was taken in this case by the Bureau except to approve it. No other address but that of a lodging house appeared on the record there.

Case 86. This case was referred to the Brooklyn Bureau of Dependent Adults, according to the records at the Manhattan Bureau. The Home record showed that the dependent was an alien. No record could be found of any request to the State Board of Charities for investigation of this case for possible deportation.

Case 93. The Committee's investigator discovered that this dependent, a young man of 18, was a non-resident of New York City, having lived in the City only 5 months. This case had been reported to the State Board of Charities from Bellevue Hospital, from which he had been transferred. The address at the Home and at the Bureau was incorrect. The correct address was learned from the State Board of Charities, where it was said that the dependent was to be returned to the place of his legal settlement.

Case 98. The Committee's investigator learned that this dependent was not a citizen, which fact also appeared on the Home records and at the Bureau. A visit was made to the daughter's address by an Examiner from the Department and the case was filed, marked "Daughter will call," as the last entry. No record could be found that the State Board of Charities had been requested to make an investigation in this case for possible deportation.

Case 112. The address of the friend of this dependent was obtained from this Home, and of that of his brother-in-law from Bellevue Hospital, from which place he had been transferred to this Home. The Home record showed this dependent to have been an alien. The case was approved at the Bureau without investigation. No addresses appeared on the history card there, and none appeared to have been secured from Bellevue Hospital. No record could be found of any request made to the State Board of Charities for investigation of this case for possible deportation.

Case 122. The wife of this dependent, who was seen at the address given, said that he was in receipt of a pension from the U. S. Government. This information was also received by the Examiner of the Department of Charities; nevertheless, the case was approved for dependence in the City Home. (See Section 80 of Article 6 of the Poor Law quoted on page 24.)

Case 123. This dependent's home was visited. His stepdaughter stated that his children had given him $10 a month for several years. The fact that the dependent was an alien appeared on the Home records. This case was referred to the Brooklyn Home, but was not investigated by the Manhattan Bureau of Dependent Adults, and no record appeared upon the history card of any report from the Brooklyn Home. This dependent remained in this Home for 51 days. No record was found that the case had been referred to the State Board of Charities for investigation for possible deportation.

Case 127. The Home record gave only a lodging house address for this inmate, showing a residence of 19 months in the United States, without naturalization. The Bureau record is to the effect that this inmate was a citizen of the United States, and had been in the State and City 19 years. The case was approved without investigation.

Case 129. The address given for the wife was visited and her new address learned. She said that her husband had been taken from this Home by their daughter to her own home. The wife expressed herself as willing to support her husband in her home. The Home records showed this dependent to have been an alien. This case was approved without investigation at the Bureau. No record

was found that this case was referred to the State Board of Charities for investigation for possible deportation. This dependent remained in the Home for a period of 107 days.

Case 145. This dependent was admitted to this Home twice during the month of May, 1912, according to the records. A visit to his address, obtained from the Home, led to an interview with him at his new address, where he was working for board and lodging. He said that his wife was earning sufficient for the support of herself and 2 children. No investigation was made in this case by the Bureau. The records there showed he was not a citizen and upon both admissions was referred to the State Board of Charities for investigation. At the end of the first 6 days he was discharged by the order of the Deputy Superintendent of the Department of State and Alien Poor of the Board, and readmitted on the same day by the Bureau of Dependent Adults. Upon the second stay he remained for a period of 96 days.

Case 177. The Committee's investigator found this man to have 5 sons and 1 daughter employed, and his landlord said that 1 son was quite prosperous. The dependent's daughter said that he was in receipt of a pension for service in the United States Navy. The Bureau records showed that the children of this man were able to pay. The case was filed, approved temporarily, pending action of the Bureau of Domestic Relations, but no further entry appeared upon the case. No record was made of the fact that he had served in the United States Army. At the expiration of 185 days stay this dependent was still in this Home.

Case 183. The address of the son of this inmate was visited, where it was discovered that he had moved to the house owned by him at Coney Island. The son was seen at his place of employment and was found to be able to support his father. The son's wife also was earning an income. No address appeared upon the history card of this inmate at the Bureau, and the admission was approved without investigation.

Case 187. This inmate was admitted without giving any residence address for himself or friends. The Home records showed that he was an alien. No record could be found that this case was referred to the State Board of Charities for investigation for possible deportation.

Case 191½. This dependent's daughter was seen at the address obtained from the Home, and said it was entirely unnecessary for him to be there, as his children would support him. She requested that he be refused admission if he applied again. The history of this inmate at the Bureau showed that he was referred to the dispensary for treatment as not a proper hospital case. From the permit stub, however, it appeared that a permit was issued for his admission to the Home without investigation.

Case 194. This dependent's sister-in-law was seen at the address given at this Home as his residence. The home gave every indication of being that of people in prosperous circumstances. At Bellevue Hospital it was learned that the patient's expenses had been paid by his son. This dependent was admitted without investigation. The Bureau records showed that he had been 1 day in the City, and the institution was notified to have papers made out for the State Board of Charities. The dependent was finally discharged from the Home to his relatives, who were willing and able to care for him.

Case 209. The Home records showed the dependent to have been an alien. The case was approved at the Bureau without investigation and without request to the State Board of Charities for investigation for possible deportation.

Case 221. The Home records showed this dependent to have been an alien. The case was approved at the Bureau without investigation, and without request to the State Board for investigation for possible deportation.

Case 230. The Home records showed this dependent to have been an alien, which fact was confirmed in an interview with his wife and himself at the address given. The Bureau history showed that the Examiner called, found no one at home, and was told to call again. The card was filed without record of any further calls. No record could be found that this case had been referred to the State Board of Charities for investigation for possible deportation.

Case 240. The Home records showed this inmate to have been an alien. The Bureau history card gave a lodging house address as his residence. The case was not investigated by the Bureau and the dependent was recorded there as a citizen. The case was approved for dependence in the City Home.

Case 244. The Home records showed that this inmate had the sum of $260.00 upon his person and that he had been in the City only 2 days. The Bureau records showed that the case was not investigated. The State Board of Charities, however, was requested to investigate this case for possible removal, and the Home was instructed to collect one dollar a day.

Case 253. At the son's address, visited by the Committee's investigator, it was learned from the janitor that the son and wife had lived here and had paid a substantial rent, and seemed to be in very comfortable circumstances. The Examiner of the Bureau visited only the inmate's address without making an effort to interview the children.

CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION

According to the official census published in the *City Record* the total number of admissions of dependents to this institution in the year 1911 was 3,460, of which number 2,482 were males and 978 females. These figures, however, do not correspond to the number of admissions as compiled from the daily census book in the Information Office of this Home, which shows the toal number of admissions in this year to have been 3,304, or 156 less than the official census. Also, upon an examination of the alphabetical register of the dependents at this Home it was found that the entries upon this book for all dependents admitted during this period were 85 less than the number of admissions entered in the census book, and 241 less than the number of admissions recorded in the official census. (Table XXI.)

The discrepancies between the total number of admissions according to the census book and according to the official census lie almost entirely between the figures entered for the first and last quarters of the year, there having been 144 less admissions according to the census book during these two quarters than according to the official census, while there were only 12 less in the second and third quarters of the year. This discrepancy was found to lie principally in the records of admissions of the males in each quarter of the year, the number of females according to the official census having been only 41 more than were entered upon the census book, while there were 115 more males according to the official census than the census book showed. As will be noticed in the same table in the second and third quarters of the year there was an excess of only 1 female on the official census over the census book.

According to the alphabetical register the total number of admissions for the year 1911 was 3,219. This approximates the total number of permits for admission issued by the Bureau of Dependent Adults in the Deputy Commissioner's Office, Brooklyn, and of transfer permits issued in the name of Kings County Hospital and Coney Island Hospital, found on file in the institution. These permits and transfers totaled for this year 3,243.

The admissions according to the permits and transfers on file were 24 more than the admissions entered upon the register; 61 less than the admissions according to the census book; and 217 less than the admissions according to the official census.

According to the official census the dependents admitted for the first 6 months of 1912 totaled 1,371, of whom 999 were males and 372 females (Table XXII). The quarterly totals for the admissions during these 6 months exactly correspond to the summaries of the daily admissions recorded in the census book kept in the office of this Home. For the same period, however, the admissions according to the entries upon the register were 1,338, which was 33 less than the number upon the census book and in the official census. Also, there were found only 1,319 permits, which were less than the admissions recorded in the official census.

Causes of Dependence

No record of the causes of dependence in any consecutive or tabulated form could be discovered in this Home. There was space for this information on the forms in the book for histories of dependents provided for by the State Board of Charities, but for reasons which will be mentioned later it was impracticable to make any deductions from these sources.

Avenues of Admission

To determine the various avenues of admission to this Home the permits and transfer slips for the year 1911 and for the first six months of 1912, also the daily reports of admissions transmitted by the clerk in the Information Office to the Brooklyn Bureau of Dependent Adults, and the entries made upon the alphabetical register of the Home were inspected.

These dependents were found to have been admitted through the following agencies:

(a) The office of the Deputy Commissioner of Charities, Brooklyn.
(b) Transfer from Kings County Hospital.
(c) Transfer from Coney Island Hospital.
(d) The male Supervising Nurse or the Matron at this Home.
(e) The Agent of the State Board of Charities.

Authority for Admissions

The authority for admission to this institution might be supposed to rest with the Superintendent of the Brooklyn Bureau of Dependent Adults, under the Second Deputy Commissioner of Charities, as that would seem to be one of the functions of this Superintendent—similar authority is vested in the Superintendents of such Bureaus in Manhattan and in Richmond. As a matter of fact, the permits issued from the office of the Deputy Commissioner of Charities, Brooklyn, are not over the name of the Superintendent of the Bureau, but are signed with the name of a clerk in his office. A large number of these permits are signed in blank in a book in which they are bound, and are afterward filled in, as occasion demands, with the names of the dependents and certain other information regarding them. The dependents presenting such permits at the Home are recorded upon the alphabetical register as having been admitted by "C of C," which is interpreted to mean by the Deputy Commissioner of Charities, Brooklyn.

Equal authority for admission to this Home seems to be vested in a representative of the Superintendent of Kings County Hospital. During the year 1911, 968, or 29.8 per cent., of the dependents, by actual count of the slips, were admitted to this Home on transfer slips over the name of the Superintendent of the Hospital (Table XXI). A few transfer permits from Coney Island Hospital, 7 in all, were found at this Home that had been accepted for admission of dependents in the year 1911.

The inability to reconcile the differing total numbers of dependents admitted to this Home shown in the various records mentioned above was also experienced when a comparison was made of the authority for the admissions to this Home as represented by the permits and transfers found at the Home, and of the authority for admissions entered for the same

period in the alphabetical register. Although the total number of permits and transfers, 3,243, approximates 3,219, the total admissions according to the register, there were found only 2,268 permits from the Deputy Commissioner of Charities' Office, which differs from the 2,326 admissions credited to the same authority on the alphabetical register (Table XXI). This would make 58 more admissions from the Deputy Commissioner's Office, according to the register, than there were permits on file. There were 108 less admissions from Kings County Hospital, according to the register, than there were permits, the total number of transfers from that institution for the year 1911 having been 860, according to the register, whereas 968 transfer slips were found at the Home. Also, 2 transfers from Coney Island Hospital were not entered upon the alphabetical register as having been admitted by the authority of its Superintendent, for there were 7 transfer permits from the Hospital found at the Home and only 5 transfers were entered upon the register for this year. This discrepancy in the two records of the authorizations for admission was found to exist not only in the yearly totals, but also between these records for practically every month in the year.

As no record of the sources of admissions was made in the daily census book in the office of this Home, nor in the quarterly official census published in the *City Record*, no comparison along this line could be made with these.

It is understood that the attention of the clerk responsible for the register of this Home was called to the discrepancies in the records for the month of December, 1911. However, discrepancies continued for the first 6 months of the year 1912, as will be apparent from a further study of Table XXII. It will be seen that there were 49 less permits from the Deputy Commissioner's Office on file for these 6 months than there were entries on the alphabetical register of admissions by his authority, the number of permits having been 869 and the entries on the register 918. Also, there were 36 more permits found for transfers from Kings County Hospital than there were dependents entered upon the register at the Home, the number of transfer permits having been 448, while the register showed only 412 transfers from this Hospital.

Although during the year 1911 there were 865 transfers to this institution from Kings County and Coney Island Hospitals according to the alphabetical register, or 975 according to the transfer permits found at the Home, and in the first 6 months of 1912 there were 414 such transfers according to the register, or 450 according to the transfer permits, this does not necessarily mean that these dependents had been receiving acute hospital treatment in the institutions from which they had been transferred. On the contrary, during the last quarter of 1911 the discharge diagnosis of 51, or 26 per cent., of the 193 dependents transferred from Kings County Hospital to this Home was "non curata." This diagnosis has been said to mean that these individuals had not been in need of hospital treatment. It may be noticed that although only 193 dependents appeared on the books of Kings County Hospital as having been transferred from that institution to this Home during these 3 months, the alphabetical register of the Home indicated that 209 dependents had been received from this Hospital in the same period, and for these transfers there were 203 permits found at the Home.

In other words, it would appear that 10 permits were issued in the name of the Superintendent of Kings County Hospital for the admis-

sion to the Home of dependents as supposed transfers who had never been patients in the Hospital, and 16 dependents were entered upon the register as transfers from the Hospital who had not been there.

It is understood that liberty is given to the supervising male nurse in this Home after the office of the Brooklyn Bureau is closed, and further permits cannot be issued for the day, to admit male applicants as lodgers that in his judgment are worthy. It is also understood that the matron in charge of the female wards has similar liberty. These lodgers are supposed to be dismissed the following morning to go to the Bureau for a permit if they desire to remain longer in the Home. In case the dependent is unable to make this trip to the Bureau it is said that the permit is asked for over the telephone. It was said that these lodgers were counted in the total number of daily admissions, but not entered upon the register. However, according to the reports made to the State Board of Charities from this almshouse, the number of lodgers during the year is inconsiderable.

A study was made of all the admissions for the month of May, 1912. According to the census book these were 240. As, however, the name appeared upon a daily census slip in the office of a dependent who was said to have been a lodger during this month but not to have been included in the 240 admissions, 241 was accepted as the number of admissions for this month. The names for these 241 admissions were secured as follows: 232 were taken from the daily reports of admissions, copies of which were found in the office of the Home; 7 were taken which did not appear on the admission reports, but which were on both the permits or the transfer slips, and the alphabetical register; to these were added 1 name from a permit which appeared neither on the daily admission reports nor on the register; and the name of the lodger mentioned above, from a daily census slip. The last name was supplied by the clerk in the Information Office when asked to explain the discrepancy between the number of permits and transfers, and the number claimed to have been admitted during that month. The other names not on the daily admission reports were discovered in a comparison of the different records.

To authorize these 241 admissions there were found at the Home 182 permits signed by a clerk in the Brooklyn Bureau, and 56 permits for the transfer of dependents to this Home from Kings County Hospital over the name of its Superintendent. Inquiry at the Hospital brought to light the fact that the Hospital had no record of 8 of these dependents having been in that institution, nor of their having been sent to this Home with these transfer permits. Also, 3 admissions to this Home in this month came in without permits. Two of these were entered as lodgers on the daily admission reports but were not entered in the alphabetical register, and 1 was entered on a daily census memorandum in the office but not on the admission report nor on the register. (Table XXIII.)

The permit books at the Brooklyn Bureau were inspected to see what record existed there of the permits found at this Home issued over the name of the clerk in the Bureau. There were in these books 183 stubs showing that this many permits had been issued for as many of these dependents to enter this Home, and 8 stubs of permits for the admission of as many to Kings County Hospital. Of these 8 dependents with permits for the Hospital, 6 were admitted at this Home on transfer slips from the Hospital bearing the same date as these permit stubs; 1 was admitted on a transfer slip dated for the day after the date of the permit stub; and the other was admitted apparently without any transfer slip 10 days after the date

on the permit stub and entered on the daily reports as coming from the Hospital.

From the permit stubs issued for admissions to the Home it was found that in 2 cases the dependents had entered the Home on the day before the date on the stubs; in 2 cases they had entered 6 and 9 days, respectively, after the date on the stubs; while in 7 cases the admissions were on the day following the date on the stub.

Control of Admissions

From January 1, 1909, to August 1, 1912, there was a total number of 977 discharges of dependents from this Home for transfer to Farm Colony. The purpose of this discharge was to relieve the congestion at the Home by filling vacancies at the Colony. The success of this measure, however, was interfered with by the readmission of a number of these same dependents at this same Home (Summary II on page 307, and Table XXIV). These 977 discharges represented a total of 869 individuals, 427, or 49 per cent., of whom left Farm Colony otherwise than by transfer or death, and 169, or 19 per cent., of whom were readmitted to the Home after their first discharge from there for transfer to the Colony.

The avenues of the readmission of 158 of these transfers was through the Deputy Commissioner of Charities' Office, Brooklyn, and of 11 by transfer from Kings County Hospital, according to the register in the Home (Table XXV). Of the 11 cases readmitted through the Hospital the majority had either made only a very brief stay there or had not even been entered on their records.

After a varying length of stay in the Home, and after 22 of the number had been allowed to pass in and out of the Home on permits from the Deputy Commissioner's Office from 2 to 9 times each, 82 of these readmitted dependents were discharged a second time from the Home for transfer to Farm Colony. Of the 87 not so discharged 11 were allowed to remain in the Home until the date of this inquiry in August, 1912, and 3 others died there. The majority of the remainder left the Home at their own request.

The result of these second discharges was similar to that which attended the initial discharges. Forty-six, or 55.8 per cent., left the Colony otherwise than by transfer or death, and 28, or 34 per cent., were readmitted to the Home. All of these 28, according to the record at the Home, were readmitted by permit from the Office of the Deputy Commissioner of Charities (Table XXVI). After a stay of different periods in the Home, and in the case of 8 of the number after readmission from 2 to 6 different times by permit to the Home, 18 of these 28 who had been admitted for the second time were again discharged for transfer to the Colony. Of this number, 11, including all that left the Colony without transfer or death, were readmitted to the Home for the third time, 10 by permit from the Deputy Commissioner of Charities' Office and 1 from Kings County Hospital. Of these 11, 8 were again sent to the Colony, and of these, 5 again left the Colony otherwise than by transfer or death. Two of these 8 were readmitted to the Home by permit from the Deputy Commissioner of Charities' Office and were allowed to leave there at their own volition. (Table XXIV.)

To check these readmissions and the readmission of dependents who were discharged from the Home for refusing to accept the transfer to

Farm Colony, the Second Deputy Commissioner of Charities wrote the following letter:

Brooklyn, N. Y., Oct. 7, 1911.

MR. M. A. MCCARTY,
Relief Clerk, Bureau of Dependent Adults,
Brooklyn, N. Y.

Dear Sir:—

It has been brought to my attention that the inmates and patients selected at Kings County institutions for transfer to Farm Colony and to Metropolitan Hospital sometimes refuse to go and take their discharge. Therefore, it is hereby ordered that any patient who is selected to be transferred to Farm Colony or to Metropolitan Hospital shall not be readmitted to any public institution in the Borough of Brooklyn, but should be referred to the Bureau of Dependent Adults, Borough of Manhattan, foot of East 26th Street, where permits will be issued for their admission into institutions in Manhattan or Farm Colony.

This rule is to be strictly enforced and carried into effect at once.

(Signed) THOMAS L. FOGARTY,
Second Deputy Commissioner.

That this letter had very little effect may be seen from the fact that of the total number of 270 readmissions of dependents in a period of 3 years and 7 months, 158, or 58.5 per cent., entered the Home again after their first discharge for transfer to the Colony within a period of 11 months after the date of the Deputy Commissioner's Letter (List II, page 313). Or, to express it differently, of the total of 169 dependents readmitted to the Home who had 1 or more times been discharged for transfer to the Colony, 101, or 59.7 per cent., were allowed to come in after this date. All of these dependents, with the exception of 7 who had come by way of Kings County Hospital, were, according to the records of the Home, admitted through the office of the Deputy Commissioner who issued the letter.

This order of the Deputy Commissioner was no more effective in preventing the readmission of those who had been discharged from the Home for refusing to be transferred to Farm Colony than in keeping out those removed for this transfer (List III, on page 316). There were, according to the records, 178 individuals discharged for such refusal in the same period, from January 1, 1909, to August 1, 1912 (Table XXVII). Of these, 47, or 26 per cent., were readmitted to the Home, 39 through the office of the Second Deputy Commissioner of Charities and 8 by transfer from Kings County Hospital (Table XXVIII). Only 6 of these readmitted dependents had their first stay in the institution after this readmission terminated by their second refusal to accept a transfer to the Colony. Three were allowed to come into this Home through the Brooklyn Bureau from 2 to 3 times each, and were finally discharged for refusing transfer to Farm Colony. Of these 47 readmissions 14, or 29 per cent., were remaining in the Home in the fall of 1912, and as many more had been allowed to leave the Home at their own volition. (Table XXVIII.)

Of the 9 discharged for their second refusal of transfer 6 were readmitted to the Home through the Deputy Commissioner of Charities' Office. Of these, 3 left by their own choice and 3 were eventually discharged for the third time for refusing to go to Farm Colony, only to let 2 be readmitted again through the Second Deputy Commissioner's Office, and 1 through Kings County Hospital. One of these last 2 absconded from the Home, but the other was discharged for the fifth time for unwillingness to go to the Colony, only to be readmitted again, and again discharged for the same reason, and finally admitted again and allowed to remain in the Home.

All statements made with regard to the readmission to the Home of

dependents discharged for refusing transfer to the Colony cover only those readmissions in which the dependents gave the same names and sufficient other data to make possible their identification as having been admitted previously. It is impossible to ascertain how many cases of readmission there were in which the dependents gave different names and so escaped detection.

With the lack of system and the absence of records in the Deputy Commissioner's office it would have been difficult, in fact, practically impossible, except in a limited number of cases, for the clerks in this office who issued permits to prevent such readmissions. These clerks would have had to depend upon their personal recognition of an applicant for readmission, as no effort had been made to record identifying data on the previous admission.

In some of the cases of the readmission of the dependents transferred to Farm Colony no record could be found at Kings County Hospital of any stay there, although, according to the register at the Home, they had been admitted on transfer slips over the name of the Superintendent of the Hospital. In the cases of others the stay at the Hospital was very brief, frequently only over night. The same facts were true of the readmissions of the dependents discharged from the Home for refusing to be transferred to the Colony.

History Records

At the Deputy Commissioner's office no record whatever was kept by the clerks of the dependents to whom they issued permits for admission to the Home, unless the stubs of the permits be called records, and there was no documentary evidence of any examination of the dependents to determine the propriety of their admission. The partial protection against improper admissions that is given the other almshouses is not apparent in connection with this institution.

The records of inmates at this Home were less complete and less serviceable than in either of the other almshouses. No effort appeared to have been made to look up previous admissions of the dependents and to connect the meager information secured on different occasions. The only history record of the institution in the Information Office that is of any practical value is the alphabetical register; but this contains no social or financial history of the dependent. It does not show whether he or she is an alien or a citizen, and does not give the length of residence in New York City. In other words, there is no evidence at this Home as to whether or not the dependent is properly a charge upon the City of New York.

The names in this alphabetical register have been allowed to so far overrun the pages apportioned to particular letters of the alphabet that entries have been made of the surnames of dependents beginning with these letters in a number of places throughout the book, wherever there were vacant pages for names beginning with other letters. When the books were first examined it was possible to locate these various entries only by reference to the clerk who kept the book, as in a majority of cases when the pages allotted to a name beginning with a certain letter had been filled there was no reference to the page or pages where the remainder of the names beginning with the same letter could be found.

This Home was designated as a State Almshouse for the reception of State Poor, after a contract had been drawn up between the State Board of Charities and the City in the year 1875 for the payment for the mainte-

nance of the State Poor, and formerly received a large number of people committed as State charges. At present, however, there is no State register of State Poor kept of cases at this Home, such as is kept at the Manhattan Home, also a State Almshouse, and the number of State Poor received here would seem to be very small.

A history of all inmates in the City Home must be kept, in accordance with Article 9, Section 142, of the Poor Law of New York State, which reads as follows:

> In addition to the general register of the inmates of the various almshouses there shall be kept a record of the sex, age, birthplace, birth of parents, education, habits, occupation, condition of ancestors and family relations, and cause of dependence of each person at the time of admission, with such other facts and particulars in relation thereto as may be required by the State Board of Charities, upon forms prescribed and furnished by such board. Superintendents and overseers of the poor, and other officers charged with the relief and support of poor persons, shall furnish to the keepers, or other officers in charge of such almshouses, as full information as practicable in relation to each person sent or brought by them to such almshouse, and such keepers or other officers shall record the information ascertained at the time of the admission of such person, on the forms so furnished. All such records shall be preserved in such almshouses, and the keepers and other officers in charge thereof shall make copies of the same on the first day of each month, and immediately forward such copies to the State Board of Charities.

This section of the law has been frequently disregarded in this Home, for of the 241 admissions of dependents during the month of May, 1912, only 106 forms in the history book furnished by the State Board of Charities were filled in in accordance with this requirement. As 4 of these 106 dependents had been previously admitted in this month, these 106 forms would correspond to 110 admissions during this time. An attempted explanation of the difference between this number and the total number of admissions was that the forms had been filled in in this same book for the dependents at their previous admissions. As, however, there had been no effort made at this institution to keep in any one place the different admissions of the same individual, as had been done at the Manhattan Home, it was necessary to make a search of the alphabetical register to ascertain what, if any, entries of previous admissions had been made for the dependents entering this Home in this month. As this necessitated looking through all the entries under one letter for each name beginning with a particular letter of the alphabet, it was evident that, except in a limited number of cases, these State history records were useless for any ready reference. In fact, it could not be discovered that anyone had ever been known to make use of them. Examining the State book for all forms corresponding to the dates of the former admissions of the dependents entering the institution in May, 37 more forms for these dependents were found. In the remaining 94 admissions in this month, or 39 per cent. of the total, no forms filled in as called for by the law were discovered.

In the case of almost none of the 147 admissions for which forms were found were the latter completely filled in with the information called for. Such important information as the citizenship of a dependent of alien birth was entered in almost none of the forms. This omission seriously interfered with the classification of the dependents in this Home (Table XXXI), contrasting it very strongly in the proportion of dependent aliens found in the Manhattan Home (Tables XV and XVIII) and Farm Colony (Tables XLI and XLIV).

Upon the bedside cards of the dependents there was a space provided

for information as to length of residence in the City, and this information was supposed to be entered upon the card when made out upon the admission of the dependent. An examination of a number of these cards showed that this particular information was infrequently placed upon them. This Home had no card census of dependents in the Information Office for ready reference, showing their location in the Home.

The addresses on record at this Home for the residences of dependents, and of the relatives or friends who were to be communicated with in case of necessity, did not seem to be up to date. A condition prevailed here similar to that already dwelt upon in connection with the other City Home. By actual investigation of 236 addresses given as the residences of the dependents admitted in May, 1912, only 76, or 32.2 per cent., proved to have been the actual addresses of the dependents just prior to admission. At 58, or 24.6 per cent., of the addresses the dependents were not known; 22, or 9.3 per cent., were addresses the dependents had left at a considerable time prior to admission to the institution; and 22, or 9.3 per cent., were addresses that were not residential. The lodging house addresses given as residences numbered 24, or 10.2 per cent. There were 4, or 1.7 per cent., addresses that were not sufficiently explicit for investigation, while 30, or 12.7 per cent., of the admissions had no addresses upon the records of this month for any residence outside of the institution. (Table XXIX.)

There were also investigated 194 addresses of relatives and friends found on the same records. Of these, 122, or 62.9 per cent., were found to have been the residences for the names given, while 36, or 18.6 per cent., were addresses where the friends or relatives were unknown. Six, or 3.1 per cent., were addresses that had been left a considerable time before the admission of the dependents to the institution. There were also 13, or 6.7 per cent., addresses that were not residential; 9, or 4.6 per cent., were not specific enough to permit of investigation; 6, or 3.1 per cent., were outside of the City; and 2, or 1 per cent., were lodging house addresses. During this month there were 36 admissions to the Home of dependents who did not give the name and residence of any friend or relative. (Table XXX.)

Character of Dependents

Section 663 of the Charter of the City of New York, describing the duty of the Commissioner of Charities to investigate the circumstances of every person admitted to the institutions under his charge, and the near relatives of every such person, has already been quoted in part in connection with the section of this Report dealing with the Manhattan Division of the City Home, and can be found by reference to page 22.

All of the admissions to this Home in May, 1912, according to the various records at the Home, numbered 241, and these were investigated. In 114 cases, or 47.3 per cent., the investigators were unable to obtain sufficient information about the dependents to allow of their classification as to the propriety of their dependence upon the City. This inability came from the following causes:

The addresses found at the Home were insufficient in	10 Cases
The dependents were unknown at the addresses given in	78 "
The addresses given were too old in	12 "
Sufficiently complete histories could not be secured in	14 "
Total	114 Cases

(a) Classification of Dependents

The remaining 127 cases were as follows:

Dependents who seemed to have had a legitimate claim upon the City's support	88, or 69.3%
Dependents who were aliens	4, " 3.1%
Dependents who did not have a legal settlement in New York City	1, " .8%
Dependents who had legally responsible relatives able to pay for their maintenance	16, " 12.6%
Dependents who were personally able to pay for their maintenance	2, " 1.6%
Dependents who were wives or children of men who had served in the U. S. Army or Navy	1, " .8%
Dependents who had relatives not legally responsible but able to pay for their maintenance	2, " 1.6%
Dependents who had relatives or friends willing to support them in their own homes	9, " 7.1%
Dependents who were able to work to earn their own support	4, " 3.1%
Total	127, or 100.0%

Accepting as correct the statement of the clerk in charge of the records at this Home that where no information was entered upon the record regarding the naturalization of an alien the dependent had not been naturalized, the records of the Home showed that there were 99 aliens admitted during this month. This number, however, has not been taken into consideration in the calculation of the following estimates of expense.

(b) Estimate of Expense

An estimate was made of the expense of the dependents having these 127 admissions, based upon the number of days each had been in the institution and the average of the daily expense for a dependent as given in the Annual Reports of the Department of Public Charities for this Home for the last 5 years. These dependents were segregated into the following groups:

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.

Dependents who were personally able to pay for their maintenance.

Dependents who were aliens.

Dependents who were non-residents of the City.

The dependents in Group I remained in this Home, after their various admissions, for a total of 2,461 days, at an estimated expense of $766.00. Had the 99 admissions of aliens during this month been counted, which would have been the correct number if all those dependents of alien birth not entered on the State history books of this Home as having become naturalized had been included in this estimate as aliens instead of only the 4 aliens that were actually included, the estimated expense for this group would have been much larger.

Group II.

Dependents who had served in the U. S. Army or Navy.

Dependents who were wives or children of men who had served in the U. S. Army or Navy.

The dependents in Group II remained in this Home for a period of 143 days, at an estimated expense of $42.77.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.

Dependents who had relatives or friends willing to support them in their own homes.

Dependents who were able to work to earn their own support.

The dependents in Group III remained in this Home, after their various admissions, for a total of 2,362 days, at an estimated expense of $706.47.

The total estimated expense to the City for merely the maintenance of the dependents in these three groups was $1,515.24.

Accepting the proportion of the different classes of dependents in the groups above, which included only the 127 admissions for which the investigators gathered sufficient information to permit of their classification, for the total of 241 admissions in the month, the estimated cost by groups of these dependents admitted during May, 1912, would have been as follows:

Group I	$1,619.44
Group II	90.42
Group III	1,493.59
Total	$3,203.45

(c) United States Soldiers and Their Families

Section 80 of Article 6 of the Poor Law of the State of New York, already quoted in the section of this Report dealing with the Manhattan Division of the City Home, provides as follows:

> No poor or indigent soldier, sailor or marine who has served in the military or naval service of the United States, nor his family, nor the families of any who may be deceased, shall be sent to any almshouse, but shall be relieved and provided for at their homes in the city or town where they may reside, so far as practicable, provided such soldier, sailor or marine, or the families of those deceased, are, and have been, residents of the State for one year. . . .

It was in disregard of this section that the widow of a soldier in the United States Army was admitted to this Home in this month of May.

(d) Removal of Aliens and Non-Residents

At the office of the Deputy Commissioner of Charities, Brooklyn, a book is kept containing duplicates of the forms filled out in requesting the State Board of Charities to remove aliens and non-residents who had been found to be public charges in Brooklyn and in Queens County. No record was found at this office of any request having been made to the State Board of Charities for the removal of aliens or non-residents from this Home in connection with their admissions during the month of May, 1912, although over 100 of the admissions were said to have been of aliens. The authority given by law to the State Board of Charities to make these removals has been quoted in this Report on page 265.

The monthly reports of the State Board of Charities of removals from the institutions of the City of New York do not show that any aliens or non-residents were removed from this Home during this month.

(e) Comparison of Findings

As no investigations had been made by the Brooklyn Bureau of Dependent Adults of any of the dependents admitted to this Home, there were no findings of the Examiners of Charitable Institutions of the Department of Public Charities with which the findings of the investigators of the Committee could be compared.

CITY FARM COLONY

During the last 6 months of the year 1911 there were 758 admissions of dependents to the Colony, according to the official census published in the *City Record*. This does not correspond to the entries upon the records at the Colony, which showed only 741 admissions in this period. The latter figure is, therefore, accepted as correct. During the first 6 months of 1912 there were 570 admissions. During the 12 months from July 1, 1911, to June 30, 1912, the total admissions were 1,311. Of these, 366 (Table XXXIV) were recorded as having come from the Borough of Manhattan, apart from 262 from the Manhattan City Home; 3 from Metropolitan Hospital; 3 from City Hospital; 40 from Municipal Lodging House; and 2 from Randalls Island, making 676, or 51.7 per cent. of the total, who came from the Borough of Manhattan.

From the Borough of Brooklyn, there were 420 from the Brooklyn City Home; 26 marked Brooklyn; and 1 from Raymond Street Hospital, making a total of 447, or 34.1 per cent. There were 118 admitted from the Borough of Richmond, apart from 10 from S. R. Smith Infirmary, Staten Island; 20 for observation as to their sanity; 1 from the House of Divine Providence; 16 reëntered on the books to correct the previous entries of their discharge; 2 admitted from the employees at the Colony; and 21 admitted by the order of the Superintendent of the Colony, making a total of 188, or 14.2 per cent., from the Borough of Richmond. Of the total of 1,311 inmates, 1,200 were males and 111 were females.

Causes of Dependence

According to the tabulation in Table XXXV the reasons governing the admission of dependents recorded at the Colony were as follows: 508, or 45 per cent., dependents were admitted in the 11 months from July 1, 1911, to May 31, 1912, because they were out of work; 189, or 16.8 per cent., because of sickness; 174, or 15.4 per cent., because of old age; 11, or 1 per cent., were epileptics; 42, or 3.7 per cent., were admitted as insane; 11, or 1 per cent., as suspected insane; 193, or 17.1 per cent., were crippled. The causes for the admission of the 183 dependents who entered in June, 1912, had not been tabulated at this institution.

Avenues of Admission

A study was made of all dependents admitted to the Colony during the month of May, 1912, numbering 98, and dependents admitted during the month of December, 1911, numbering 145. These dependents were found to have been admitted to this institution through the following agencies:

(a) The Bureau of Dependent Adults, Manhattan.
(b) The Bureau of Dependent Adults, Brooklyn.
(c) The Bureau of Dependent Adults, Richmond.
(d) Transfer from New York City Home for the Aged and Infirm, Manhattan Division.

(e) Transfer from New York City Home for the Aged and Infirm, Brooklyn Division.
(f) Transfer from Metropolitan Hospital.
(g) Transfer from City Hospital.
(h) Transfer from Municipal Lodging House.
(i) Transfer from S. R. Smith Infirmary, Staten Island.
(j) Transfer from House of Divine Providence.
(k) Order of the Superintendent of the Colony.
(l) Commitment to the Psychopathic Ward of the Colony for observation as to sanity.

Seventy-six, or 31.2 per cent. of the dependents admitted in these months, came through the Manhattan Bureau (Table XXXIV). The next largest number was 65, or 26.8 per cent., transferred from the Brooklyn Home. The next largest number was 35, or 14.4 per cent., transferred from Municipal Lodging House. The number admitted through the Bureau of Dependent Adults, Richmond, was 21, or 8.7 per cent.; the Manhattan Home transferred 21, or 8.7 per cent.; 4, or 1.6 per cent., were designated only as from Brooklyn; 7, or 2.9 per cent., were admitted for observation as to their sanity; 3, or 1.2 per cent., came from S. R. Smith Infirmary; 2, or 0.8 per cent., were reëntered on the books to correct the census; 6, or 2.5 per cent., were allowed admission by the order of the Superintendent; 2, or 0.8 per cent., came from Metropolitan Hospital; and 1, or 0.4 per cent., from House of Divine Providence, S. I.

Authority for Admissions

The authority for admission to the Colony is divided between the Superintendent of the Manhattan Bureau and the Superintendent of the Richmond Bureau. Dependents admitted by transfer from the Brooklyn Home are accompanied by permits from the office of the Second Deputy Commissioner of Charities, in Brooklyn, but applications for these transfers are understood to be made from the Brooklyn Home to the Superintendent of the Manhattan Bureau, and such transfers are supposed to be made only with his authority and upon the approval on medical grounds, or after actual medical inspection of the dependents, by the General Inspector of the Department. As the Colony has had attached to it a Psychopathic Ward for the observation of the alleged or suspected insane, such cases are also received through commitment by magistrates. Records of such commitments, however, are kept in the Richmond Bureau.

There should, therefore, be a permit from one of the three Bureaus of Dependent Adults or commitment papers from a magistrate to accompany every dependent admitted.

For the 98 admissions in the month of May, 1912, there were found at the Colony 37 permits from the Manhattan Bureau of Dependent Adults, in which were included the permits for the transfer of 15 dependents from the Manhattan Home. There were also 17 permits for the transfer of dependents from the same City Home to the Colony, and 2 for transfer from Metropolitan Hospital, making a total of 56 permits for the admission of dependents from Manhattan. For the 15 dependents admitted from Brooklyn in this month there were found the corresponding number of permits. The same is true for the 11 dependents admitted through the Bureau of Rich-

mond. There were 7 dependents committed to the Psychopathic Ward by magistrates, with the authorization for each on file at the Colony.

For the other 9 dependents admitted in this month there were no permits or papers authorizing their admission on file at the Colony. These were as follows: 1 for observation as to sanity; 1 admission from House of Divine Providence, Staten Island; 2 admissions of former inmates of Farm Colony; 1 admission of a former inmate of Municipal Lodging House; 1 admission of a recent inmate of some institution on Blackwell's Island which was not specified; also, 3 entries of inmates as having been admitted in this month who, according to the records, had been erroneously entered as discharged in the months of October, 1911, and March, 1912, respectively, the error in making the discharge entries having apparently only been discovered in the month of May. (Table XXXVI.)

The permits counted do not correspond to the entries upon the books of the Colony, which show that there were 58 admissions from the Manhattan Bureau, the Manhattan Home, and Metropolitan Hospital. The 11 shown on the books as admitted through the Richmond Bureau, and the 15 as coming from Brooklyn, with the 7 suspected of insanity, have corresponding authorizations for their admission. According to the books there were 6 readmissions in this month by the order of the Superintendent, who would seem in this case to have exercised some of the functions of a Superintendent of a Bureau of Dependent Adults.

The books at the Manhattan Bureau containing the stubs of the permits for the admission of dependents to the various institutions were examined to ascertain what record there was at this place of the authorization for the admissions to the Colony in the months of December, 1911, and May, 1912. It was found that there were only 34 stubs of permits at the Bureau for the 41 admissions made to the Colony from this Bureau and from the City Home during December, according to the records on the books at the Colony. No permit stubs nor other records were discovered at the Bureau authorizing the transfer of the 35 dependents that were sent from Municipal Lodging House in December and were admitted to the Colony with a letter from the Superintendent of the Lodging House to the Superintendent of the Colony stating that he was sending these dependents "as requested." In the month of May, 1912, there were only 56 permit stubs found for the 58 admissions from Manhattan.

Two dependents during this month of May came into the institution 6 days after the date of the issuance of the permits for admission. These were Brooklyn residents admitted to one of the cottages. Two dependents transferred from Metropolitan Hospital were admitted 3 days after the permits were issued, and 17 dependents transferred from the Manhattan Home were admitted on the day preceding the date of the permits, while another dependent transferred from the same institution was admitted 3 days before the date of his permit.

At the Brooklyn Bureau only 46 permit stubs could be found for the 54 transfers from this Bureau and from the Brooklyn Home in the month of December, 1911. For 15 similar transfers in the month of May, 1912, there were found only 11 permit stubs.

For the 10 dependents entered on the books of the Colony as admitted through the Richmond Bureau in December, 1911, there were 8 permit stubs found at this Bureau. For 11 similarly entered in May, 1912, there were 10 permit stubs found and record of 1 commitment.

There was admitted to the Colony in the month of December, 1911, 1

dependent presenting a permit bearing the name of the Superintendent of the Manhattan Bureau for which no stub could be located at this Bureau. According to the record, this dependent had no home. His nearest relative, however, was entered as a resident of New Jersey, and this dependent had been naturalized in that State. There were 2 other dependents admitted in this month who gave Blackwell's Island only as their address for whom no permit stub could be found at the Manhattan Bureau, but whom the Colony records showed to have been previous inmates of the Colony. Another dependent from Manhattan, a woman, whose husband was at the Colony, according to their records, was admitted to this institution in December, but no permit stub could be found for her at this Bureau. A former inmate on Blackwell's Island, with residence in Manhattan, had no permit stub at the Manhattan Bureau for his admission, and another dependent with a Manhattan address was entered upon the records of the admissions in December to correct an entry as an absconder in the preceding month.

There were 7 entries of admissions in this month of dependents for whom Brooklyn addresses were given, but for none of whom was a permit stub discovered at the Brooklyn Bureau. At the Brooklyn Home 1 of these was found, according to the records, to have been transferred from this Home on the date received at the Colony. Two others were found to have been transferred from the City Home in Brooklyn 2 and 5 months previous to the month of December, respectively. Another Brooklyn resident who was a former inmate of the Colony was admitted in this month for whom there was no permit stub at the Brooklyn Bureau. The remaining 3 of these 7 had also been inmates of the Brooklyn Home, but were not, according to their records, transferred from that Home at the time of this admission to the Colony.

A previous resident of Farm Colony who gave a Staten Island address was also admitted during this month of December for whom no permit stub could be found at the Richmond Bureau, and also no history card. Two entries during this month were of 2 inmates who had been entered as having left the Colony; 1 during the preceding month, and the other 8 months previously, the mistake having been rectified only after the lapse of these intervals.

During the month of May, 1912, there were admitted to the Colony 4 former inmates with Manhattan addresses for whose admission at this time no authority could be found on the permit stubs at the Manhattan Bureau. For 3 of these there were no permits found at the Colony. There was also 1 admission during this month from House of Divine Providence of a dependent concerning whom the Richmond Bureau had no record. According to the books, 3 errors were corrected this month by reëntering dependents who had been recorded as discharged; 1 7 months, 1 6 months, and 1 2 months previously.

Control of Admissions

Owing to the peculiar nature of this institution the majority of its admissions are by transfer from other boroughs rather than through the Bureau of Dependent Adults in Richmond. As has already been set forth under the heading, "Authority for Admissions," there were some cases which had been readmitted by the order of the Superintendent of the Colony for which no record of authorization could be found at the Richmond Bureau. Also, there were 21 admissions in the year from July 1, 1911, to June 30,

1912, for which this was the only authority entered upon the books at the Colony. (Table XXXIV.)

History Records

For the year 1911 there was no record file kept of the histories of the inmates admitted to the Colony through the Manhattan Bureau; consequently no evidence was found at this Bureau of any effort having been made to gather information regarding the dependents sent to the Colony beyond what was entered upon the permits issued by the Bureau for their admission to the Colony. This information did not include any statements regarding the financial ability or inability of the applicants or their relatives to relieve the City of the cost of their maintenance. In the year 1912, although more effort was made to secure the histories of dependents admitted to all institutions in the Department, and although history cards were found at this Bureau for all but 5 of the dependents for whom there were also stubs of permits for the Colony, no investigation seemed to have been made of any of these dependents at this time by this Bureau. No effort whatever appeared to have been made by the Brooklyn Bureau during the entire years of 1911 and 1912 either to fill out any history cards or to make any investigation of the dependents for whose admission to the Colony permits were issued.

At the Richmond Bureau a record of each of the alleged insane committed in December, 1911, and May, 1912, was found. No histories were taken and no investigation made in the case of 6 dependents admitted in December for whom there were permit stubs at this Bureau. Entry was made upon the record of another dependent who, according to the Colony history, had been at that place in each of the years from 1907 to 1911, to the effect that a permit had been issued because this dependent had overstayed his leave of absence from the Colony and the Superintendent insisted upon his readmission. For another dependent admitted through the Bureau during these months notification was sent to the Superintendent of the Colony, after investigation, to discharge him as not being a proper charge upon the City. This appeared to be the only admission during this month through this Bureau of which any investigation was made.

Four of the admissions in May, 1912, for which permits were issued by this Bureau were without investigation. Two of them were former inmates of the Colony whose readmission was approved by its Superintendent; another had been an absconder from the Colony and had returned there after 30 days in the Richmond County jail for vagrancy, and the other had also been an inmate of the Colony.

The 5 other dependents admitted by permit from the Richmond Bureau during this month were as follows: 1 who upon investigation proved to have been unknown at the address given and who was afterward discharged for not giving a correct address; 1 temporarily admitted to the Colony pending arrangement with his son who removed him from the Colony the day following his admission; 1 recommended for admission to the Colony by the Superintendent of the Bureau on account of her being almost constantly under hospital treatment which, in the opinion of the Superintendent, would be most economically furnished to her at the Colony; 1 who was removed by her husband the following month; and 1 who was a previous resident of the Colony and in the judgment of the Bureau was a case for retention there.

In view of the inadequacy of the records kept at the Bureau it was evident that the provision of the law was not being complied with by the Superintendents. Section 142 of Article 9 of the State of New York reads as follows:

> In addition to the general register of the inmates of the various almshouses, there shall be kept a record of the sex, age, birth-place, birth of parents, education, habits, occupation, condition of ancestors and family relations, and cause of dependence of each person at the time of admission, with such other facts and particulars in relation thereto as may be required by the State Board of Charities, upon forms prescribed and furnished by such board. Superintendents and overseers of the poor, and other officers charged with the relief and support of poor persons, shall furnish to the keepers or other officers in charge of such almshouses as full information as practicable in relation to each person sent or brought by them to such almshouses, and such keepers or other officers shall record the information ascertained at the time of admission of such person on the forms so furnished. All such records shall be preserved in such almshouses, and the keepers and other officers in charge thereof shall make copies of the same on the first day of each month, and immediately forward such copies to the State Board of Charities.

A history form in the book furnished by the State Board of Charities was found at the Colony for each of the admissions during these months of December, 1911, and May, 1912, although these blanks were frequently only partially filled out. No effort seems to have been made on the part of the Superintendents of the Bureaus of Dependent Adults to comply with the latter part of this Section of the Poor Law, which makes it mandatory upon officers charged with the relief and support of poor persons to furnish full information for each person sent to this institution. In a large number of cases the dependents are received at the Colony with no other information than that contained on the permits for admission, and their histories, which may have been taken in full at the institution from which they have been transferred, must be taken anew at the Colony.

The record clerk at the Colony evidently makes some effort to connect the various admissions of the same dependent, but this work appears to be much less thoroughly done than at the Manhattan Home.

The Colony possessed the only card census of inmates found in the almshouses of the City. In addition to this file a book is kept in which is recorded, day by day, the names and other identifying data of all dependents admitted, and of all discharged or having died on each day. As the Colony is not a State Almshouse no State register for State Poor cases is kept here.

The addresses of dependents kept at the Colony were found to be unsatisfactory for reasons similar to those given in connection with the two City Homes. The 91 residence addresses of dependents that were investigated for the admissions during the month of May, 1912, were found to fall into the following classes: 13, or 14.3 per cent., were found to have been the residences of the dependents just prior to admission to the Home; 35, or 38.4 per cent., were addresses where the dependents were not known; 8, or 8.8 per cent., were addresses which the dependents had left at a considerable time prior to their admission; 2, or 2.2 per cent., of the addresses given were not residential addresses; 12, or 13.2 per cent., were lodging house addresses; 2, or 2.2 per cent., were outside of the City; 12, or 13.2 per cent., were addresses insufficient for investigation; and 7, or 7.7 per cent., of the dependents were admitted without any residential address. (Table XXXVII.)

On the records of these same May admissions 90 addresses of friends or relatives given for notification in case of necessity were investigated:

24, or 26.7 per cent., were found to have been the actual residences of the relatives or friends; 32, or 35.5 per cent., were addresses where these friends were not known; 5, or 5.6 per cent., were addresses which the friends or relatives had left at a considerable time before the admission of the dependents; 9, or 10 per cent., were out-of-town addresses; 3, or 3.3 per cent., were lodging house addresses; 8, or 8.9 per cent., of the addresses were insufficient for investigation; 9, or 10 per cent., of the addresses were not residential. (Table XXXVIII.)

In the month of December, 1911, of the 109 addresses of dependents that were investigated, only 9, or 8.2 per cent., were found to have been the correct addresses of the dependents just prior to admission; 1, or 0.9 per cent., was an old address; and 1, or 0.9 per cent., was outside of the City. At 8, or 7.3 per cent., of the addresses the dependents were unknown; 5, or 4.6 per cent., of the addresses were other than residential; 7, or 6.4 per cent., were insufficient for a visit; 13, or 12 per cent., were addresses of lodging houses; while 65, or 59.7 per cent., of the admissions this month had upon their history records at the Colony no address of any residence outside of the institutions of New York. (Table XXXIX.)

In this same month of December 67 addresses of relatives and friends were examined and only 22 of them, or 32.8 per cent., were found to have been accurate (Table XL); 1, or 1.4 per cent., was an old address; 15, or 22.4 per cent., were out-of-town addresses; 15, or 22.4 per cent., were addresses where these friends were unknown; 3, or 4.5 per cent., were lodging house addresses; 6, or 9 per cent., were addresses of places that were not residential; while 5, or 7.5 per cent., were addresses insufficient for a visit.

Character of Dependents

An examination was made of all the admissions to the Colony during the month of May, 1912, amounting to 98, and of 90 of the 145 admissions during the month of December, 1911 (the remaining 55 cases in December were not investigated on account of the pressure of other work), to see what action had been taken in accordance with the powers and duties of the Commissioner of Public Charities, conferred by Section 663 of the Charter of the City of New York, as follows:

> It shall be the duty of the Commissioner of Public Charities to investigate the circumstances of every person admitted to an institution under his charge and of the near relatives of such person. Such investigation shall be made, when practicable, before the admission of such person, and the results of investigation shall be placed on file and preserved with the records of the Department . . .

Investigators of the Committee could not secure sufficient information for 51, or 52 per cent., of the 98 admissions in the month of May, 1912, to make their classification possible. This failure was due to the following reasons:

The addresses found at the Colony were insufficient in	13	Cases
The dependents were unknown at the addresses given in	31	"
The addresses given were too old in	3	"
Sufficiently complete histories could not be secured in	4	"
Total	51	Cases

(a) Classification of Dependents

In the remaining 47 cases the facts seemed to justify their classification as follows:

Dependents who seemed to have had a legitimate claim upon the City's support	17, or 36.2%
Dependents who were aliens	16, " 34.0%
Dependents who had legally responsible relatives able to pay for their maintenance	1, " 2.1%
Dependents who were personally able to pay for their maintenance	1, " 2.1%
Dependents who had served in the U. S. Army or Navy	1, " 2.1%
Dependents who had relatives, willing to support them in their own homes	1, " 2.1%
Dependents who were able to work to earn their own support	1, " 2.1%
Dependents who were committed by magistrates for observation as to their sanity	7, " 15.0%
Dependents who had relatives not legally responsible but able to pay for their maintenance	2, " 4.3%
Total	47, or 100.0%

(b) Estimate of Expense

The expense of the maintenance of these 47 dependents by the City was estimated as follows: From the history books of the Colony were secured the different periods of stay of these dependents at the Colony. The periods of stay of those dependents who were remaining in the Colony in August when this examination was made were reckoned only to the date of examination. The per capita per diem expense per dependent in the Colony as published in the Annual Reports of the Department was used and an average estimated for the last 5 years. This average was used as the multiplier in estimating at what expense these dependents had been maintained in this institution. As the records of the various admissions of the same dependents are much less carefully associated at this institution, it is probable that an underestimate has been made of the number of days of stay of these dependents. Also, as it is understood, the per capita per diem expense given in the Annual Reports of the Department corresponds to the maintenance expense of the dependents and the local expense incurred in the development of the property, and does not include any portion of the general administrative expense of the Department, the expense incurred on corporate stock issues, or any other expense of a general nature. The figures given, therefore, in the following estimate only partially represent the actual cost incurred by the City for these dependents.

Owing to the fact that this institution was comparatively a small one until the recent opening of the new dormitories, the opportunity for length of stay was much less here than at the older Homes in Brooklyn and Manhattan.

The dependents regarding whom findings have just been given were segregated into the following groups, as in connection with the City Homes in this Report:

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.

Dependents who were personally able to pay for their maintenance.

Dependents who were aliens.

Dependents who were non-residents of the City.

The dependents in Group I remained in the Colony, after their various admissions, 1,722 days, at an estimated expense to the City for maintenance of $808.48.

Group II.
Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

The dependents in Group II remained in the Colony, after the various admissions, 263 days, at an estimated expense to the City for maintenance of $123.49.

Group III.
Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

The dependents in Group III remained in the Colony, after their various admissions, 454 days, at an estimated expense to the City for maintenance of $213.15. This would make a total estimated cost to the City of these dependents under these three groups of $1,145.12. (Table XLII.)

Had the proportions in the different classes of the dependents that could be classified held good for all admitted during this month, the cost of maintenance of these three groups would have been as follows:

Group I	$1,755.79
Group II	165.82
Group III	447.62
Total	$2,369.23

The 90 cases for the month of December, 1911, were even less productive of satisfactory information, for, of this number, 55, or 61.8 per cent., of these cases were dependents about whom sufficient information could not be gathered, for the following reasons:

The addresses found at the Colony were insufficient in	23 Cases
The dependents were unknown at the addresses given in	27 "
Sufficiently complete histories could not be secured in	5 "
Total	55 Cases

(aa) Classification of Dependents

The remaining 35 cases were found to consist of the following:

Dependents who seemed to have had a legitimate claim upon the City's support	10, or 28.6%
Dependents who were aliens	17, " 48.6%
Dependents who had legally responsible relatives able to pay for their maintenance	4, " 11.5%
Dependents who were personally able to pay for their maintenance	2, " 5.7%
Dependents who were able to work to earn their own support	1, " 2.8%
Dependents who had relatives willing to support them in their own homes	1, " 2.8%
Total	35, or 100.0%

(bb) Estimate of Expense

Employing the same groupings for the month of December as for May, it was found that the dependents in Group I remained at the Colony for a total of 5,537 days, at an expense of $2,599.62; that there were no dependents for Group II; and that those for Group III remained in the institution

a total of 159 days, at an expense of $74.65, making a total estimated cost to the City for these dependents of $2,674.27.

Extending these same proportions to all of the admissions in this month the cost of maintenance of these dependents would thus have fallen into groups as follows:

Group I	$10,956.50
Group III	314.62
Total	$11,271.12

(c) United States Soldiers and Families

A portion of Section 80 of Article 6 of the Poor Law of the State of New York is again quoted as follows:

> No poor or indigent soldier, sailor or marine who has served in the military or naval service of the United States, nor his family, nor the families of any who may be deceased, shall be sent to any almshouse, but shall be relieved and provided for at their homes in the city or town where they may reside, so far as practicable, provided such soldier, sailor or marine or the families of those deceased, are, and have been, residents of the State for one year. . . .

In disregard of this prohibition a former soldier in the U. S. Army was admitted to this Colony during the month of May.

(d) Removal of Aliens and Non-Residents

Under Section 17 of Article 2 of the State Charities Law, which has been quoted in part in this Report on page 265, the State Board of Charities, and any of its officers and members may at any time visit the institutions subject to its supervision and remove all aliens and non-residents who are public charges for transportation to the proper states or countries.

During the month of May, 1912, there were 14 aliens in this institution, and in December, 1911, there were 15, all of whom were recorded as aliens upon the books of the Colony. There is no evidence that any of these aliens were reported to the State Board of Charities by the Colony, and the monthly reports of the State Board of Charities do not show that any of them were removed from this institution by the Board.

Although 84 of the 98 dependents admitted to the Colony in May, 1912, had previously been inmates of municipal institutions, as was shown upon the records of the Colony—some having been in more than one institution—and although 5 other dependents admitted had previously been inmates of private institutions, no evidence was apparent of any effort having been made to obtain the previous histories of these dependents either by the Colony itself or by the Bureau of Dependent Adults of Manhattan, Richmond, or Brooklyn.

The same lack of effort appeared in connection with admissions in the month of December, 1911, when 119 of the 145 inmates appeared upon the records of the Colony as previous inmates of municipal institutions and 3 other inmates appeared as having been in private institutions.

(e) Comparison of Findings

For the admissions to the Colony in the month of December, 1911, there could be found no history cards and no records of any investigation by any one of the three Bureaus of Dependent Adults. The admissions in May,

1912, through the Brooklyn Bureau also had not been investigated and had no history cards at the Bureau. Only 4 of the admissions through the Manhattan Bureau were found to have come under the observation of the Superintendent of the Bureau or one of his Examiners, and no investigation appeared to have been made by this Bureau in connection with any of these admissions. Consequently there were no findings to be compared with the findings of the Committee's investigators.

There were a few cases for which records were on file at the Richmond Bureau. A comparison of two of these records and the findings of the Committee's investigators follows:

Case 10. The investigator of the Committee found that this dependent had a son and a married daughter who were able and willing to care for and maintain their mother. The dependent was said to have entered the Colony because of a difference with her husband.

The Bureau had a record of this case 2 years before the time of this admission to the effect that this dependent was living on the charity of neighbors and had no one else to aid her. Within 2 weeks of the time of this admission the history card at the Bureau was marked disapproved. The dependent remained in the institution for 19 days and, according to the records at the Colony, was taken away from there by her husband at her own request.

Case 61. The investigator of the Committee received information at a former place of employment of this dependent that he had no relatives in this country. The records at the Colony showed that this dependent was an alien.

The Bureau had no information on its history card regarding the family of this dependent. The record there was to the effect that he had been 30 days in jail for vagrancy. No evidence was found to show that this case had been reported to the State Board of Charities for investigation for possible deportation.

TABLE I.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Admissions from January 1, 1911, to December 31, 1911.[1]

	Sources																
	Commissioner of Charities		Bellevue Hospital		Metropolitan Hospital		City Hospital		Harlem Hospital		Workhouse		Farm Colony		Lebanon Hospital		Total
1911	Male	Fem.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
January	207	81	2	4	2	6	3	17	2	1	1	1	..	..	1	1	329
February	110	63	4	5	6	8	10	12	4	4	..	..	..	..	..	..	226
March	217	95	9	4	8	12	5	..	3	4	..	..	..	1	..	1	359
April	216	88	13	10	8	5	9	9	2	2	..	2	..	..	..	1	365
May	291	120	18	23	..	1	1	2	4	6	1	1	..	..	..	1	469
June	259	107	18	8	17	12	1	1	6	3	..	3	..	..	..	..	435
July	174	65	23	20	1	2	..	..	3	4	2	2	1	..	..	..	297
August	246	86	26	15	14	10	1	..	4	1	1	..	..	1	..	..	405
September	177	54	14	10	12	1	1	5	2	3	..	..	..	..	..	..	279
October	241	72	19	12	7	8	2	11	1	3	..	2	..	..	..	..	378
November	175	84	15	15	6	1	1	4	2	2	..	2	1	..	..	..	308
December	161	75	10	11	12	5	1	3	3	2	..	1	..	..	..	..	284
Total	2,474	990	171	137	93	71	35	64	36	35	5	14	2	2	1	4	4,134

NOTE: 647, or 15.6 per cent. of the total admissions, were by transfers from hospitals. 47, or 16.5 per cent. of the total admissions in December, were by transfers from hospitals.

[1] Taken from the monthly reports.

TABLE II.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Admissions from January 1, 1912, to June 30, 1912.[1]

	Sources														
	Commissioner of Charities		Bellevue Hospital		Metropolitan Hospital		City Hospital		Harlem Hospital		Workhouse		Farm Colony		Total
1912	Male	Fem.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
January	132	75	12	12	10	..	..	2	5	3	..	..	..	..	251
February	119	48	15	18	..	..	1	1	2	3	3	..	..	..	210
March	193	72	32	22	20	6	1	3	9	3	..	4	2	..	367
April	219	77	19	21	4	3	..	2	5	6	..	..	..	..	356
May	200	83	42	32	1	..	4	..	4	4	..	2	1	..	373
June	171	93	27	29	36	2	13	1	8	5	..	..	2	..	387
Total	1,034	448	147	134	71	11	19	9	33	24	3	6	5	0	1,944

NOTE: 448, or 23.5 per cent. of the total admissions, were by transfers from hospitals. 87, or 23.3 per cent. of the total admissions in May, were by transfers from hospitals.

[1] Taken from the monthly reports.

TABLE III.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Causes of Dependence of Inmates Admitted from January 1, 1912, to June 30, 1912.[1]

1912	Lack of Employment	Sickness	Aged and Infirm	Blind	Lost	Unknown	Total
January	85	90	68	7	...	1[2]	251
February	72	85	52	1	...	...	210
March	161	135	71	...	...	...	367
April	199	120	37	...	...	...	356
May	134	175	60	1	2	1	373
June	130	210	47	...	...	...	387
Total	781	815	335	9	2	2	1,944
Percentage	40.2	42.0	17.2	.4	.1	.1	100.0

[1] Taken from the monthly reports.

[2] Alcoholic.

TABLE IV.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Authorizations for Admission Found on File at the Home for the 186 Male Admissions in December, 1911.[1]

ADMISSIONS HAVING AUTHORIZATIONS AT THE HOME FROM THE BUREAU OF DEPENDENT ADULTS		181
Permits bearing the name of the Superintendent of the Bureau	165	
Permits bearing the name of the Examining Physician	15	
Permits without Physician's name from the office of the Examining Physician	1	
	181	
ADMISSIONS NOT HAVING AUTHORIZATIONS AT THE HOME FROM THE BUREAU OF DEPENDENT ADULTS		5
Admission slips bearing the name of a doctor at Harlem Hospital	2	
Admission slips from the Reception Hospital bearing the name of an interne at Metropolitan Hospital	1	
Admissions for which there were no slips or permits found on file at the Home	2	
	5	
Total		186

[1] Taken from the admission records.

TABLE V.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Authorizations for Admission Found on File at the Home for the 253 Male Admissions in May, 1912.[1]

ADMISSIONS HAVING AUTHORIZATIONS AT THE HOME FROM THE BUREAU OF DEPENDENT ADULTS		243
Permits bearing the name of the Superintendent of the Bureau	142	
Permits bearing the name of the Examining Physician	101	
	243	
ADMISSIONS NOT HAVING AUTHORIZATIONS AT THE HOME FROM THE BUREAU OF DEPENDENT ADULTS		10
Admission slips bearing the name of a doctor at Harlem Hospital	4	
Admission slips bearing the names of doctors on Blackwells Island	4	
Admission slips bearing the name of the Superintendent of New York City Farm Colony	1	
Admissions for which there were no slips or permits found on file at the Home	1	
	10	
Total		253

[1] Taken from the admission records.

TABLE VI.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Records of Authorizations Found at the Bureau of Dependent Adults, Manhattan, for the 253 Male Admissions to the Home in May, 1912,[1] Compared with the Authorizations for Admission Found on File at the Home.

ADMISSIONS HAVING STUBS OF PERMITS AT THE BUREAU OF DEPENDENT ADULTS		134
With permits at the Home bearing the name of the Superintendent of the Bureau	134	
ADMISSIONS NOT HAVING STUBS OF PERMITS AT THE BUREAU OF DEPENDENT ADULTS		119
With permits at the Home bearing the name of the Superintendent of the Bureau	8	
With permits at the Home bearing the name of the Examining Physician	101	
With admission slips at the Home bearing the name of a doctor at Harlem Hospital	4	
With admission slips at the Home bearing the names of doctors on Blackwell's Island	4	
With admission slips at the Home bearing the name of the Superintendent of Farm Colony	1	
With no admission slips or permits on file at the Home	1	
	119	
Total		253

[1] Taken from the admission records.

ANALYSIS OF THE 574 DISCHARGES FROM NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION, FOR TRANSFER TO NEW YORK CITY FARM COLONY, FROM JANUARY 1, 1910, TO JUNE 30, 1912; THEIR DISPOSAL AT FARM COLONY; AND THEIR READMISSION TO THE CITY HOME.

SUMMARY NO. I.

First Discharge

I. PROCESS OF TRANSFER

Dependents discharged first time for transfer		554
Dependents who failed to arrive at Farm Colony	23	
Dependents who arrived at Farm Colony	531	
	554	

II. DISPOSAL AT FARM COLONY

Dependents received on first transfer		531
Dependents remaining at Farm Colony in August, 1912	235	
Dependents who died at Farm Colony	21	
Dependents retransferred to other institutions	35	
Dependents who left Farm Colony without transfer or death	240	
	531	
Dependents who left Farm Colony without transfer or death		240

III. DEPENDENTS READMITTED TO CITY HOME AFTER FIRST DISCHARGE 103

Second Discharge		
I. Process of Transfer		
Dependents discharged second time for transfer		17
Dependents who failed to arrive at Farm Colony	1	
Dependents who arrived at Farm Colony	16	
	17	
II. Disposal at Farm Colony		
Dependents received on second transfer		16
Dependents remaining at Farm Colony in August, 1912	5	
Dependents who died at Farm Colony	1	
Dependents who left Farm Colony without transfer or death	10	
	16	
Dependents who left Farm Colony without transfer or death		10
III. Dependents Readmitted to City Home After Second Discharge		4
Third Discharge		
I. Process of Transfer		
Dependents discharged third time for transfer		2
Dependents who arrived at Farm Colony	2	
II. Disposal at Farm Colony		
Dependents received on third transfer		2
Dependents remaining at Farm Colony in August, 1912	1	
Dependents who left Farm Colony without transfer or death	1	
	2	
Dependents who left Farm Colony without transfer or death		1
III. Dependents Readmitted to City Home After Third Discharge		1
Fourth Discharge		
I. Process of Transfer		
Dependents discharged fourth time for transfer		1
Dependents who arrived at Farm Colony	1	
II. Disposal at Farm Colony		
Dependents retransferred to other institutions	1	
III. Dependents Readmitted to City Home		0

TABLE VII.

Rearrangement of Summary No. I, with Totals Added.

	Process of Transfer				Disposal at Farm Colony			
	Readmitted to City Home	Total Discharged	Failed to Arrive at F. C.	Arrived at F. C.	Remaining at F. C.	Died at F. C.	Transfers from F. C. to Other Inst'ns	All Others Who Left F. C.
First Discharge	...	554	23	531	235	21	35	240
Readmitted	103	....	....	....	....	....	....	....
Second Discharge	...	17	1	16	5	1	....	10
Readmitted	4	....	....	....	....	....	....	....
Third Discharge	...	2	....	2	1	....	....	1
Readmitted	1	....	....	....	....	....	....	....
Fourth Discharge	...	1	....	1	....	....	1	....
	108	574	24	550	241	22	36	251

TABLE VIII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Dependents Readmitted After Their First Discharge from the City Home, between January 1, 1910, and June 30, 1912, for Transfer to New York City Farm Colony.

Reasons for Leaving Farm Colony		Means of Readmission to the Home		Disposition at the Home	
Failed to arrive at Farm Colony	6	Bureau of Dependent Adults	96	Died	10
On Farm Colony book as not discharged	1	Transferred by order of Dr. Schultze	1	Transferred to Pay Roll	1
Absconded	46	Transferred from Metropolitan Hospital	2	Transferred to State Register	1
By own request	20	Transferred from Farm Colony	4	Discharged to State Board of Charities Agent	1
Overstayed passes	6			Transferred to Farm Colony	13
Discharged by order of Superintendent	7			Refused to work	2
Transferred to Metropolitan Hospital	1			Remaining in the Home, August 1, 1912	16
Transferred to Manhattan State Hospital	1			Unknown	59
Transferred to City Home	6				
Transferred to City Hospital	2				
Transferred to Pay Roll	2				
Unexplained	5				
Total	103	Total	103	Total	103

TABLE IX.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings as to the History Records at the Bureau of Dependent Adults, Manhattan, for the 253 Male Admissions in May, 1912,[1] Compared with the Authorizations for Admission Found on File at the City Home.

ADMISSIONS HAVING HISTORY RECORDS AT THE BUREAU OF DEPENDENT ADULTS		217
With permits at the Home bearing the name of the Superintendent of the Bureau	115	
With permits at the Home bearing the name of the Examining Physician	100	
With admission slips at the Home bearing the name of a doctor at Harlem Hospital	1	
With no permits or admission slips at the Home (this history card is for a previous admission)	1	
	217	
ADMISSIONS NOT HAVING HISTORY RECORDS AT THE BUREAU OF DEPENDENT ADULTS		36
With permits at the Home bearing the name of the Superintendent of the Bureau	27	
With permits at the Home bearing the name of the Examining Physician	1	
With admission slips at the Home bearing the name of a doctor at Harlem Hospital	3	
With admission slips at the Home bearing the names of doctors on Blackwell's Island	4	
With admission slips at the Home bearing the name of the Superintendent of Farm Colony	1	
	36	
		253

[1] Taken from the admission records.

TABLE X

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings as to the Reviews of the History Records at the Bureau of Dependent Adults, Manhattan, by the Examiners of Charitable Institutions and the Superintendent of the Bureau for the 253 Male Admissions in May, 1912,[1] Compared with the Stubs of Permits for Admission to the Home Found at the Bureau.

ADMISSIONS HAVING HISTORY RECORDS AT THE BUREAU REVIEWED BY AN EXAMINER OR THE SUPERINTENDENT		101
With permit stubs at the Bureau	9	
With no permit stubs at the Bureau	92	
	101	
ADMISSIONS HAVING HISTORY RECORDS AT THE BUREAU NOT REVIEWED BY AN EXAMINER OR THE SUPERINTENDENT		116
With permit stubs at the Bureau	100	
With no permit stubs at the Bureau	16	
ADMISSIONS NOT HAVING HISTORY CARDS AT THE BUREAU		36
With permit stubs at the Bureau	25	
With no permit stubs at the Bureau	11	
	36	
Total		253

[1] Taken from the admission records.

TABLE XI.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings, After Investigation, Regarding the Residence Addresses of 166 Dependents Entered upon the Records of Admission in December, 1911.

Residences of dependents just prior to admission	20, or 12.0%
Residences of dependents at some time before admission	3, " 1.8%
Addresses where dependents were not known	35, " 21.0%
Addresses of lodging houses	49, " 29.5%
Addresses that were not residential	9, " 5.5%
Addresses that were not sufficiently explicit for investigation	4, " 2.4%
Addresses that were outside of the City	3, " 1.8%
Dependents admitted without residential addresses	43, " 26.0%
Total	166, or 100.0%

TABLE XII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings, After Investigation, Regarding the Residence Addresses of 161 Relatives and Friends of Dependents Entered upon the Records of Admission in December, 1911.

Residences of relatives or friends just prior to the admission	65, or 40.4%
Residences of relatives or friends at some time before the admission	9, " 5.6%
Addresses where relatives or friends were not known	40, " 24.8%
Addresses of lodging houses	8, " 5.0%
Addresses that were not residential	12, " 7.5%
Addresses that were not sufficiently explicit for investigation	6, " 3.7%
Addresses that were outside of the City	21, " 13.0%
Total	161, or 100.0%

NOTE: The records for 35 admissions during this month had no names and addresses of relatives or friends entered upon them.

TABLE XIII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings, After Investigation, Regarding the Residence Addresses of 231 Dependents Entered upon the Records of Admission in May, 1912.

Residences of dependents just prior to admission	62, or 26.9%
Residences of dependents at some time before admission	4, " 1.7%
Addresses where dependents were not known	60, " 26.0%
Addresses of lodging houses	55, " 23.9%
Addresses that were not residential	10, " 4.3%
Addresses that were not sufficiently explicit for investigation	3, " 1.2%
Addresses that were outside of the City	1, " .4%
Dependents admitted without residential addresses	36, " 15.6%
Total	231, or 100.0%

TABLE XIV.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings, After Investigation, Regarding the Residence Addresses of 246 Relatives and Friends of Dependents Entered upon the Records of Admission in May, 1912.

Residences of relatives or friends just prior to the admission	137, or 55.6%
Residences of relatives or friends at some time before the admission	9, " 3.6%
Addresses where relatives or friends were not known	50, " 20.2%
Addresses of lodging houses	12, " 4.8%
Addresses that were not residential	16, " 6.5%
Addresses that were not sufficiently explicit for investigation	7, " 2.8%
Addresses that were outside of the City	15, " 6.5%
Total	246, or 100.0%

NOTE: The records for 26 admissions during this month had no names and addresses of relatives or friends entered upon them.

TABLE XV.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings, After Investigation, Regarding the Character of the 186 Male Dependents Admitted in December, 1911.

ADMISSIONS THAT COULD NOT BE CLASSIFIED AS TO CHARACTER FOR THE FOLLOWING REASONS:		99
The addresses found at the Home were insufficient in	37 Cases	
The dependents were unknown at the addresses given in	40 "	
The addresses given were too old in	3 "	
Sufficiently complete histories could not be secured in	19 "	
Total	99 Cases	
ADMISSIONS CLASSIFIED AS TO CHARACTER:		87
Dependents who seemed to have had a legitimate claim upon the City's support	29, or 33.3%	
Dependents who were aliens	38, " 43.6%	
Dependents who did not have a legal settlement in New York City	12, " 13.8%	
Dependents who had legally responsible relatives able to pay for their maintenance	2, " 2.3%	
Dependents who were personally able to pay for their maintenance	2, " 2.3%	
Dependents who had served in the U. S. Army or Navy	2, " 2.3%	
Dependents who had relatives willing to support them in their own homes	1, " 1.2%	
Dependents who were able to work to earn their own support	1, " 1.2%	
Total	87, or 100.0%	
		186

TABLE XVI.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Estimate of Expense to the City of the Maintenance of Male Dependents Admitted in December, 1911, and Found, After Investigation, to Fall into Certain Groups.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.

Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$5,363.11
Group II	235.69
Group III	102.48
Total	$5,701.28

TABLE XVII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Estimate of Expense to the City of the Maintenance of Male Dependents Admitted in December, 1911: for Those Found, After Investigation, to Fall into the Groups Shown; and for Those Who Could Not be Classified, but Who Would Have Fallen into These Groups on the Basis of the Proportions in Each Group of Those Classified.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.

Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$10,726.22
Group II	471.38
Group III	204.96
Total	$11,402.56

TABLE XVIII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Findings, After Investigation, Regarding the Character of the 253 Dependents Admitted in May, 1912.

ADMISSIONS THAT COULD NOT BE CLASSIFIED AS TO CHARACTER FOR THE FOLLOWING REASONS:		87
The addresses found at the Home were insufficient in	24 Cases	
The dependents were unknown at the addresses given in	43 "	
The addresses given were too old in	1 Case	
Sufficiently complete histories could not be secured in	19 Cases	
Total	87 Cases	
ADMISSIONS CLASSIFIED AS TO CHARACTER:		166
Dependents who seemed to have had a legitimate claim upon the City's support	86, or 51.8%	
Dependents who were aliens	50, " 30.2%	
Dependents who did not have a legal settlement in New York City	4, " 2.4%	
Dependents who had legally responsible relatives able to pay for their maintenance	11, " 6.6%	
Dependents who were personally able to pay for their maintenance	2, " 1.2%	
Dependents who had served in the U. S. Army or Navy	3, " 1.8%	
Dependents who had relatives willing to support them in their own homes	2, " 1.2%	
Dependents who had relatives not legally responsible but able to pay for their maintenance	4, " 2.4%	
Dependents who were able to work to earn their own support	4, " 2.4%	
Total	166, or 100.0%	
		253

TABLE XIX.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Estimate of Expense to the City of the Maintenance of Male Dependents Admitted in May, 1912, and Found, After Investigation, to Fall into Certain Groups.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.

Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$3,793.72
Group II	1,579.94
Group III	485.52
Total	$5,859.18

TABLE XX.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Estimate of Expense to the City of the Maintenance of Male Dependents Admitted in May, 1912: for Those Found, After Investigation, to Fall into the Groups Shown; and for Those Who Could Not be Classified, but Who Would Have Fallen into These Groups on the Basis of the Proportions in Each Group of Those Classified.

Group I.
- Dependents who had legally responsible relatives able to pay for their maintenance.
- Dependents who were personally able to pay for their maintenance.
- Dependents who were aliens.
- Dependents who were non-residents of the City.

Group II.
- Dependents who had served in the U. S. Army or Navy.
- Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.
- Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
- Dependents who had relatives or friends willing to support them in their own homes.
- Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$5,774.30
Group II	2,404.78
Group III	739.00
Total	$8,918.08

LIST I.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN DIVISION.

Readmissions of Dependents Discharged from This Home for Transfer to New York City Farm Colony, the Discharges Having Taken Place from January 1, 1910, to June 30, 1912.

EXPLANATION OF ABBREVIATIONS:

B.D.A.	Bureau of Dependent Adults, Manhattan.
F.C.	Discharged for transfer to Farm Colony.
Met. Hosp.	Metropolitan Hospital.
State Reg.	Entered upon the State Register as a State Poor person.
State Agt.	Discharged in custody of Agent of the State Board of Charities.
On Reg.	Name of dependent on Register at this Home.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
3	Nov. 8, 1911	B.D.A.	Feb. 29, 1912	.....
4	Aug. 17, 1911	B.D.A.	Apr. 22, 1912	.....
"	June 25, 1912	B.D.A.	July 15, 1912	.....
6	May 11, 1912	B.D.A.	On Reg. Jan. 1, 1913	
8	Jan. 8, 1912	B.D.A.	Apr. 15, 1912	.....
9	Dec. 11, 1911	B.D.A.	Dec. 29, 1911	Died
15	June 24, 1912	City Hosp.	On Reg. Jan. 1, 1913	
16	June 10, 1912	B.D.A.	On Reg. Jan. 1, 1913	
18	May 16, 1912	B.D.A.	May 28, 1912	.....

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
22	Mar. 25, 1912	B.D.A.	May 2, 1912	.....
"	May 7, 1912	B.D.A.	May 17, 1912	.....
"	May 20, 1912	B.D.A.	May 21, 1912	F.C.
27	July 12, 1912	B.D.A.	On Reg. Jan. 1, 1913	
30	Apr. 12, 1912	B.D.A.	Apr. 30, 1912	F.C.
36	Mar. 7, 1912	B.D.A.	June 18, 1912	F.C.
43	June 6, 1912	B.D.A.	On Reg. Jan. 1, 1913	
50	July 17, 1912	B.D.A.	Aug. 8, 1912	F.C.
55	June 13, 1912	B.D.A.	On Reg. Jan. 1, 1913	
57	June 26, 1912	B.D.A.	June 27, 1912	.....
64	Apr. 22, 1912	B.D.A.	On Reg. Jan. 1, 1913	
84	May 31, 1912	B.D.A.	June 17, 1912	.....
97	July 19, 1912	B.D.A.	July 22, 1912	F.C.
119	June 13, 1912	B.D.A.	On Reg. Jan. 1, 1913	
151	June 20, 1912	F.C.	June 21, 1912	.....
"	July 8, 1912	B.D.A.	On Reg. Jan. 1, 1913	
186	June 20, 1912	F.C.	On Reg. Jan. 1, 1913	
213	Mar. 17, 1911	B.D.A.	Nov. 4, 1912	To pay roll
215	Dec. 19, 1910	B.D.A.	Dec. 20, 1910	F.C.
216	Mar. 14, 1911	Transferred by order of Dr. Schultze	Apr. 14, 1911	Died
218	July 8, 1910	B.D.A.	Sept. 20, 1910	.....
"	Sept. 26, 1910	B.D.A.	Nov. 3, 1910	.....
"	Nov. 9, 1911	B.D.A.	On Reg. Dec. 2, 1912	
221	Apr. 27, 1910	B.D.A.	May 6, 1910	F.C.
"	Dec. 3, 1910	B.D.A.	Dec. 6, 1910	F.C.
"	June 20, 1911	B.D.A.	Oct. 11, 1911	F.C.
222	May 26, 1910	B.D.A.	June 3, 1910	.....
"	Oct. 29, 1910	B.D.A.	Nov. 4, 1910	.....
"	Nov. 4, 1910	B.D.A.	Sept. 13, 1911	.....
223	Apr. 29, 1910	B.D.A.	May 2, 1910	State Reg.
229	Apr. 22, 1910	B.D.A.	Aug. 16, 1911	Died
232	July 15, 1910	B.D.A.	Aug. 31, 1910	.....
"	Oct. 31, 1910	B.D.A.	Dec. 12, 1910	.....
"	Dec. 28, 1910	B.D.A.	Feb. 14, 1911	.....
"	June 12, 1911	B.D.A.	June 15, 1911	.....
"	Aug. 10, 1911	B.D.A.	Sept. 5, 1911	.....
"	Sept. 11, 1911	B.D.A.	Feb. 19, 1912	.....
233	Aug. 31, 1910	B.D.A.	Oct. 20, 1910	.....
"	Nov. 4, 1910	B.D.A.	Nov. 22, 1910	.....
234	July 18, 1910	B.D.A.	July 25, 1910	Died
235	May 9, 1910	B.D.A.	May 10, 1910	Refused to work
236	June 11, 1910	B.D.A.	June 13, 1910	Refused to work
"	June 27, 1910	B.D.A.	July 23, 1910	.....
"	Aug. 17, 1910	B.D.A.	Aug. 23, 1910	.....
"	Aug. 26, 1910	B.D.A.	Aug. 29, 1910	Refused to work
"	Sept. 1, 1910	B.D.A.	Oct. 17, 1910	.....
"	Oct. 18, 1910	B.D.A.	Oct. 22, 1910	.....
"	Jan. 3, 1911	B.D.A.	Jan. 12, 1911	F.C.
"	Aug. 13, 1912	B.D.A.	Aug. 21, 1912	.....
"	Oct. 21, 1912	B.D.A.	Dec. 2, 1912	.....
241	July 28, 1910	B.D.A.	Aug. 30, 1910	.....
"	Sept. 16, 1910	B.D.A.	May 5, 1911	.....
"	Aug. 12, 1911	B.D.A.	Aug. 21, 1911	.....
"	Oct. 18, 1911	B.D.A.	May 27, 1912	.....
"	June 26, 1912	B.D.A.	Sept. 16, 1912	.....
"	Sept. 28, 1912	B.D.A.	On Reg. Dec. 2, 1912	
247	July 13, 1910	B.D.A.	Aug. 18, 1910	Died
248	Aug. 17, 1910	B.D.A.	Oct. 7, 1910	Died
251	Aug. 3, 1910	B.D.A.	July 17, 1911	.....
"	July 2, 1912	B.D.A.	On Reg. Dec. 2, 1912	

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
253	Aug. 11, 1910	B.D.A.	Oct. 4, 1910	.....
"	Apr. 22, 1911	B.D.A.	Aug. 10, 1911	.....
"	Oct. 2, 1911	B.D.A.	May 20, 1912	.....
"	June 5, 1912	B.D.A.	Aug. 6, 1912	.....
"	Aug. 28, 1912	B.D.A.	Nov. 20, 1912	.....
254	May 29, 1911	B.D.A.	Sept. 9, 1912	.....
"	Sept. 13, 1912	B.D.A.	On Reg. Dec. 2, 1912	
259	Aug. 31, 1911	B.D.A.	Mar. 16, 1912	.....
"	Aug. 29, 1912	B.D.A.	Sept. 5, 1912	F.C.
261	July 6, 1910	B.D.A.	July 7, 1910	.....
"	July 9, 1910	B.D.A.	July 20, 1910	.....
"	Aug. 8, 1910	B.D.A.	Oct. 7, 1910	.....
"	Oct. 10, 1910	B.D.A.	Nov. 10, 1910	F.C.
"	July 10, 1911	B.D.A.	Sept. 11, 1911	.....
"	Sept. 14, 1911	B.D.A.	Jan. 22, 1912	.....
"	Jan. 25, 1912	B.D.A.	May 10, 1912	.....
"	May 13, 1912	B.D.A.	May 21, 1912	F.C.
"	Oct. 16, 1912	B.D.A.	On Reg. Dec. 2, 1912	
263	Feb. 23, 1911	B.D.A.	July 24, 1911	To City Hosp.
"	July 31, 1911	B.D.A.	Aug. 5, 1912	.....
"	Aug. 12, 1912	B.D.A.	On Reg. Dec. 2, 1912	
267	Dec. 14, 1911	B.D.A.	Dec. 19, 1911	F.C.
268	July 26, 1910	B.D.A.	Apr. 26, 1911	.....
"	July 28, 1911	B.D.A.	Oct. 9, 1911	.....
"	Dec. 11, 1911	B.D.A.	Mar. 14, 1912	.....
271	Aug. 23, 1910	B.D.A.	Aug. 23, 1910	.....
274	July 3, 1912	B.D.A.	July 22, 1912	.....
276	July 1, 1911	B.D.A.	Nov. 27, 1911	.....
"	June 13, 1912	B.D.A.	Sept. 19, 1912	.....
277	July 2, 1912	B.D.A.	July 8, 1912	.....
278	Dec. 7, 1910	B.D.A.	Dec. 15, 1910	.....
281	Sept. 9, 1911	B.D.A.	June 18, 1912	.....
282	Nov. 15, 1910	B.D.A.	On Reg. Dec. 2, 1912	
284	Apr. 18, 1911	B.D.A.	June 18, 1912	F.C.
285	Nov. 29, 1910	B.D.A.	Dec. 7, 1910	State Agt.
288	Mar. 8, 1912	Met. Hosp.	Mar. 20, 1912	.....
"	Apr. 26, 1912	B.D.A.	June 26, 1912	.....
290	Dec. 22, 1910	B.D.A.	May 8, 1911	.....
"	May 8, 1911	B.D.A.	June 29, 1911	F.C.
"	Aug. 18, 1911	B.D.A.	Sept. 12, 1911	.....
291	Oct. 5, 1911	B.D.A.	Aug. 8, 1912	F.C.
301	Nov. 28, 1910	B.D.A.	Nov. 29, 1910	F.C.
"	Dec. 16, 1911	Met. Hosp.	Dec. 26, 1911	.....
"	Dec. 21, 1911	B.D.A.	Dec. 27, 1911	.....
304	Jan. 3, 1911	B.D.A.	Jan. 14, 1911	.....
"	June 22, 1911	B.D.A.	June 24, 1911	.....
309	Nov. 14, 1910	B.D.A.	June 29, 1911	F.C.
313	Nov. 15, 1911	B.D.A.	Nov. 16, 1911	.....
316	Nov. 29, 1911	B.D.A.	June 24, 1912	.....
"	Oct. 29, 1912	B.D.A.	On Reg. Dec. 2, 1912	
321	Mar. 14, 1911	B.D.A.	Mar. 18, 1911	.....
"	Mar. 24, 1911	B.D.A.	Aug. 17, 1911	.....
"	Feb. 8, 1912	B.D.A.	Mar. 19, 1912	.....
323	Dec. 27, 1911	B.D.A.	Apr. 23, 1912	.....
324	Mar. 18, 1912	B.D.A.	Apr. 16, 1912	.....
325	Nov. 29, 1911	B.D.A.	Apr. 20, 1912	.....
327	Dec. 8, 1910	B.D.A.	Feb. 22, 1911	.....
329	May 31, 1911	B.D.A	June 1, 1911	.....
336	Oct. 9, 1911	B.D.A.	Feb. 29, 1912	F.C.
"	Nov. 4, 1912	B.D.A.	On Reg. Dec. 2, 1912	

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
338	Jan. 12, 1911	B.D.A.	Mar. 20, 1911	.....
"	Apr. 4, 1911	B.D.A.	Apr. 25, 1911	.....
"	July 15, 1911	B.D.A.	Aug. 7, 1911	.....
339	Jan. 11, 1912	Met. Hosp.	Apr. 22, 1912	.....
340	Feb. 23, 1912	B.D.A.	Sept. 26, 1912	.....
353	May 16, 1912	F.C.	On Reg. Dec. 2, 1912	
363	May 11, 1911	B.D.A.	July 3, 1911	Died
364	Apr. 3, 1911	B.D.A.	On Reg. Dec. 2, 1912	
370	Jan. 3, 1911	B.D.A.	June 12, 1911	.....
382	June 6, 1911	B.D.A.	June 8, 1911	F.C.
387	July 21, 1911	B.D.A.	Oct. 9, 1911	.....
"	Oct. 20, 1911	B.D.A.	Apr. 22, 1912	.....
388	Jan. 6, 1912	B.D.A.	Apr. 19, 1912	.....
390	Jan. 16, 1912	B.D.A.	Apr. 11, 1912	.....
"	Apr. 23, 1912	Bellevue Hosp.	May 3, 1912	.....
"	Nov. 4, 1912	B.D.A.	Nov. 18, 1912	.....
"	Nov. 19, 1912	B.D.A.	On Reg. Dec. 2, 1912	
397	Apr. 3, 1911	B.D.A.	Apr. 20, 1911	.....
"	May 8, 1911	B.D.A.	May 23, 1911	.....
"	May 29, 1911	B.D.A.	June 13, 1911	.....
400	Aug. 10, 1911	B.D.A.	Sept. 5, 1912	F.C.
401	Apr. 4, 1911	B.D.A.	July 11, 1911	.....
"	Jan. 29, 1912	B.D.A.	Apr. 11, 1912	.....
407	Sept. 12, 1911	B.D.A.	May 14, 1912	.....
"	Aug. 12, 1912	B.D.A.	Sept. 16, 1912	.....
"	Oct. 14, 1912	B.D.A.	On Reg. Dec. 2, 1912	
410	Nov. 25, 1911	B.D.A.	Dec. 23, 1911	.....
"	June 18, 1912	B.D.A.	On Reg. Dec. 2, 1912	
425	Aug. 4, 1911	B.D.A.	Aug. 8, 1911	.....
429	Dec. 28, 1911	B.D.A.	Apr. 23, 1912	F.C.
437	Jan. 20, 1912	B.D.A.	On Reg. Dec. 20, 1912	
444	Sept. 6, 1911	B.D.A.	Aug. 13, 1912	.....
"	Aug. 22, 1912	B.D.A.	On Reg. Dec. 2, 1912	
448	Oct. 31, 1911	B.D.A.	Nov. 3, 1911	.....
"	May 2, 1912	B.D.A.	On Reg. Dec. 2, 1912	
449	Nov. 27, 1911	B.D.A.	On Reg. Dec. 2, 1912	
450	Nov. 27, 1911	B.D.A.	July 24, 1912	.....
"	July 25, 1912	B.D.A.	On Reg. Dec. 2, 1912	
452	Nov. 14, 1911	B.D.A.	May 10, 1912	Died
455	Nov. 16, 1911	B.D.A.	May 20, 1912	.....
"	July 9, 1912	B.D.A.	Nov. 6, 1912	.....
458	Dec. 4, 1911	B.D.A.	Apr. 23, 1912	.....
466	Jan. 10, 1912	B.D.A.	On Reg. Dec. 2, 1912	
473	July 6, 1912	B.D.A.	On Reg. Dec. 2, 1912	
478	Sept. 14, 1911	B.D.A.	Feb. 18, 1912	Died
481	July 1, 1912	B.D.A.	On Reg. Dec. 2, 1912	
494	Apr. 4, 1912	B.D.A.	Apr. 26, 1912	Died
501	Nov. 26, 1912	F.C.	On Reg. Dec. 2, 1912	
502	July 18, 1911	B.D.A.	On Reg. Dec. 2, 1912	

TABLE XXI.

New York City Home for the Aged and Infirm, Brooklyn Division.

Comparison of Various Records of Admissions for the Year 1911.

EXPLANATION OF ABBREVIATIONS:

C. of C.—Admissions by the Deputy Commissioner of Charities' Office, Brooklyn.
K.C.H.—Admissions by transfer from Kings County Hospital.
C.I.H.—Admissions by transfer from Coney Island Hospital.

	Permits and Transfers.				Alphabetical Register.					Census Book.			Official Census.		
1911	C. of C.	K.C.H.	C.I.H.	Total	C. of C.	K.C.H.	C.I.H.	State	Total	M.	F.	Total	M.	F.	Total
January.....	188	128	...	316	190	102	...	2	294	235	71	306	...	...	...
February.....	117	104	...	221	137	100	...	2	239	149	73	222	...	...	...
March.....	167	110	...	277	163	83	...	1	247	170	84	254	...	...	...
Total 1st qr....	472	342	...	814	490	285	...	5	780	554	228	782	609	257	866
April.....	181	80	...	261	182	55	...	2	239	191	77	268	...	...	...
May.....	269	75	3	347	281	72	3	7	363	270	99	369	...	...	...
June.....	221	76	2	299	220	72	...	3	295	209	106	315	...	...	...
Total 2d qr....	671	231	5	907	683	199	3	12	897	670	282	952	671	282	953
July.....	190	74	...	264	195	64	...	2	261	180	89	269	...	...	...
August.....	203	67	1	271	206	67	1	3	277	206	73	279	...	...	...
September.....	210	51	...	261	218	36	...	1	255	190	73	263	...	...	...
Total 3d qr....	603	192	1	796	619	167	1	6	793	576	235	811	586	236	822
October.....	188	49	...	237	198	48	...	2	248	198	50	248	...	...	...
November.....	192	62	1	255	186	62	1	1	250	193	73	266	...	...	...
December.....	142	92	...	234	150	99	...	2	251	176	69	245	...	...	...
Total 4th qr...	522	203	1	726	534	209	1	5	749	567	192	759	616	203	819
Total for year.	2,268	968	7	3,243	2,326	860	5	28	3,219	2,367	937	3,304	2,482	978	3,460

TABLE XXII.

New York City Home for the Aged and Infirm, Brooklyn Division.

Comparison of Various Records of Admissions from January 1 to June 30, 1912.

EXPLANATION OF ABBREVIATIONS:

C. of C.—Admissions by the Deputy Commissioner of Charities' Office, Brooklyn.
K.C.H.—Admissions by transfer from Kings County Hospital.
C.I.H.—Admissions by transfer from Coney Island Hospital.

	Permits and Transfers.				Alphabetical Register.					Census Books.			Official Census.		
1912	C. of C.	K.C.H.	C.I.H.	Total	C. of C.	K.C.H.	C.I.H.	State	Total	M.	F.	Total	M.	F.	Total
January.....	137	110	...	247	135	81	...	1	217	179	71	250	...	...	...
February.....	107	72	...	179	105	78	...	...	183	128	61	189	...	...	...
March.....	92	82	...	174	105	81	...	2	188	127	52	179	...	...	...
Total 1st qr....	336	264	...	600	345	240	...	3	588	434	184	618	434	184	618
April.....	158	58	2	218	158	59	2	2	221	168	60	228	...	...	...
May.....	182	56	...	238	193	52	...	...	245	180	60	240	...	...	...
June.....	193	70	...	263	222	61	...	1	284	217	68	285	...	...	...
Total 2d qr....	533	184	2	719	573	172	2	3	750	565	188	753	565	188	753
Total half year.	869	448	2	1,319	918	412	2	6	1,338	999	372	1,371	999	372	1,371

TABLE XXIII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Authorizations for Admission Found on File at the Home for the 241 Admissions in May, 1912.

ADMISSIONS HAVING AUTHORIZATIONS AT THE HOME FROM THE BUREAU OF DEPENDENT ADULTS		182
Permits bearing the name of a clerk in the Bureau of Dependent Adults	182	
ADMISSIONS NOT HAVING AUTHORIZATIONS AT THE HOME FROM THE BUREAU OF DEPENDENT ADULTS		59
Transfer slips bearing the name of the Superintendent of Kings County Hospital	56	
Admissions entered on the daily admission reports for which there were no permits or transfer slips found on file and no entries on the alphabetical register at the Home	2	
Admissions for which there were no entries on the daily admission reports, no permits or transfer slips found on file, and no entries on the alphabetical register	1	
	59	
Total		241

ANALYSIS OF THE 977 DISCHARGES FROM NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION, FOR TRANSFER TO NEW YORK CITY FARM COLONY, FROM JANUARY 1, 1909, TO AUGUST 1, 1912; THEIR DISPOSAL AT FARM COLONY; AND THEIR READMISSION TO THE CITY HOME.

SUMMARY NO. II.

First Discharge

I. PROCESS OF TRANSFER

Dependents discharged first time for transfer		869
Dependents who failed to arrive at Farm Colony	88	
Dependents who arrived at Farm Colony	781	
	869	

II. DISPOSAL AT FARM COLONY

Dependents received on first transfer		781
Dependents remaining at Farm Colony in August, 1912	260	
Dependents who died at Farm Colony	56	
Dependents retransferred to other institutions	38	
Dependents who left Farm Colony without transfer or death	427	
	781	
Dependents who left Farm Colony without transfer or death		427

III. DEPENDENTS READMITTED TO CITY HOME AFTER FIRST DISCHARGE	169

Second Discharge

I. Process of Transfer

Dependents discharged second time for transfer		82
Dependents who failed to arrive at Farm Colony	15	
Dependents who arrived at Farm Colony	67	
	82	

II. Disposal at Farm Colony

Dependents received on second transfer		67
Dependents remaining at Farm Colony in August, 1912	19	
Dependents who died at Farm Colony	1	
Dependents retransferred to other institutions	1	
Dependents who left Farm Colony without transfer or death	46	
	67	
Dependents who left Farm Colony without transfer or death		46

III. Dependents Readmitted to City Home After Second Discharge	28

Third Discharge

I. Process of Transfer

Dependents discharged third time for transfer		18
Dependents who failed to arrive at Farm Colony	4	
Dependents who arrived at Farm Colony	14	
	18	

II. Disposal at Farm Colony

Dependents received on third transfer		14
Dependents remaining at Farm Colony in August, 1912	4	
Dependents who left Farm Colony without transfer or death	10	
	14	
Dependents who left Farm Colony without transfer or death		10

III. Dependents Readmitted to City Home After Third Discharge	11

Fourth Discharge

I. Process of Transfer

Dependents discharged fourth time for transfer		8
Dependents who arrived at Farm Colony	8	

II. Disposal at Farm Colony

Dependents received on fourth transfer		8
Dependents remaining at Farm Colony in August, 1912	2	
Dependents who died at Farm Colony	1	
Dependents who left Farm Colony without transfer or death	5	
	8	
Dependents who left Farm Colony without transfer or death		5

III. Dependents Readmitted to City Home After Fourth Discharge	2

Fifth Discharge

Dependents discharged fifth time for transfer	0

TABLE XXIV.

REARRANGEMENT OF SUMMARY NO. II, WITH TOTALS ADDED.

	Process of Transfer				Disposal at Farm Colony			
	Readmitted to City Home	Total Discharged	Failed to Arrive at F. C.	Arrived at F. C.	Remaining at F. C.	Died at F. C.	Transfers from F. C. to Other Inst'ns	All Others Leaving F. C.
First Discharge...	....	869	88	781	260	56	38	427
Readmitted.....	169	....	....	....	....	....	....	....
Second Discharge.	...	82	15	67	19	1	1	46
Readmitted.....	28	....	....	....	....	....	....	....
Third Discharge..	....	18	4	14	4	....	....	10
Readmitted.....	11	....	....	....	....	....	....	....
Fourth Discharge.	....	8	....	8	2	1	....	5
Readmitted.....	2	....	....	....	....	....	....	....
Total.....	210	977	107	870	285	58	39	488

TABLE XXV.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Dependents Readmitted After Their First Discharge from the Home, between January 1, 1909, and August 1, 1912, for Transfer to New York City Farm Colony.

REASONS FOR LEAVING FARM COLONY		MEANS OF READMISSION TO THE HOME		DISPOSITION AT THE HOME	
Failed to arrive at Farm Colony	6	Office of Second Deputy Commissioner of Charities	158	Died	3
Absconded	121	Transferred from Kings County Hospital	11	Discharged for refusing transfer to Farm Colony	6
By own request	19			Absconded	4
Overstayed Passes	7			Discharged at own request	80
Transferred to Metropolitan Hospital	1			Sent to Bureau of Dependent Adults, Brooklyn	4
Discharged by order of the Superintendent	4			Transferred to Kings County Hospital	1
Unexplained	11			Transferred to Farm Colony	60
				Remaining in the Home August, 1912	11
Total	169	Total	169	Total	169

TABLE XXVI.

New York City Home for the Aged and Infirm, Brooklyn Division.

Dependents Readmitted After Their Second Discharge from the Home, between January 1, 1909, and August 1, 1912, for Transfer to New York City Farm Colony.

Reasons for Leaving Farm Colony		Means of Readmission to the Home		Disposition at the Home	
Failed to arrive at Farm Colony	6	Office of Second Deputy Commissioner of Charities	28	Discharged at own request	14
Absconded	15			Discharged for refusing transfer to Farm Colony	4
By own request	2			Transferred to Farm Colony	10
Overstayed Passes	1				
Discharged by order of Superintendent	1				
Entered on Farm Colony discharge book as not discharged	1				
Unexplained	2				
Total	28	Total	28	Total	28

TABLE XXVII.

New York City Home for the Aged and Infirm, Brooklyn Division.

Discharges of Dependents for Refusing to be Transferred to New York City Farm Colony, Their Readmissions, and Their Disposal After Readmissions.

	Readmitted to City Home	Remaining in City Home	Died at City Home	Transferred to Farm Colony	Discharged, Miscellaneous	Discharged for Refusing Farm Colony
First Discharge	....	....	....	....	....	178
Readmitted	47	14	1	....	....	....
Second Discharge	....	....	....	8	15	9
Readmitted	6	....	....	....	....	....
Third Discharge	....	....	....	....	....	3
Readmitted	2	....	....	....	....	....
Fourth Discharge	....	....	....	....	....	1
Readmitted	1	1	....	....	....	....
Fifth Discharge	....	....	....	....	....	1
Readmitted	1	....	....	....	....	....
Sixth Discharge	....	....	....	....	....	0
Total	57	15	1	8	15	192

TABLE XXVIII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Dependents Readmitted After Their First Discharge from the Home, between January 1, 1910, and August 1, 1912, for Refusing Transfer to New York City Farm Colony.

MEANS OF READMISSION TO THE HOME		DISPOSITION AT THE HOME	
Bureau of Dependent Adults	39	Absconded	2
Kings County Hospital	8	Refused transfer to Farm Colony	6
		Discharged at own request	14
		Transferred to Farm Colony	8
		Remaining in Home December, 1912	14
		Transferred to Ward 33, Kings County Hospital	1
		Died	1
		Sent to Bureau of Dependent Adults	1
Total	47	Total	47

TABLE XXIX.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Findings, After Investigation, Regarding the Residence Addresses of 236 Dependents Entered upon the Records of Admission to the Home in May, 1912.

Residences of dependents just prior to admission	76, or 32.2%
Residences of dependents at some time before admission	22, " 9.3%
Addresses where dependents were not known	58, " 24.6%
Addresses of lodging houses	24, " 10.2%
Addresses that were not residential	22, " 9.3%
Addresses that were not sufficiently explicit for investigation	4, " 1.7%
Dependents admitted without residential addresses	30, " 12.7%
	236, or 100.0%

TABLE XXX.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Findings, After Investigation, Regarding the Residence Addresses of 194 Relatives and Friends of Dependents Entered Upon the Records of Admission in May, 1912.

Residences of relatives or friends just prior to the admission	122, or 62.9%
Residences of relatives or friends at some time before the admission	6, " 3.1%
Addresses where relatives or friends were not known	36, " 18.6%
Addresses of lodging houses	2, " 1.0%
Addresses that were not residential	13, " 6.7%
Addresses that were not sufficiently explicit for investigation	9, " 4.6%
Addresses that were outside of the City	6, " 3.1%
	194, or 100.0%

NOTE: The records for 36 admissions during this month had no names and addresses of relatives or friends entered upon them.

TABLE XXXI.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Findings, After Investigation, Regarding the Character of the 241 Dependents Admitted in May, 1912.

ADMISSIONS THAT COULD NOT BE CLASSIFIED AS TO CHARACTER FOR THE FOLLOWING REASONS:		114
The addresses found at the Home were insufficient in	10 Cases	
The dependents were unknown at the addresses given in	78 "	
The addresses given were too old in	12 "	
Sufficiently complete histories could not be secured in	14 "	
	114 Cases	
ADMISSIONS CLASSIFIED AS TO CHARACTER:		127
Dependents who seemed to have had a legitimate claim upon the City's support	88, or 69.3%	
Dependents who were aliens	4, " 3.1%	
Dependents who did not have a legal settlement in New York City	1, " .8%	
Dependents who had legally responsible relatives able to pay for their maintenance	16, " 12.6%	
Dependents who were personally able to pay for their maintenance	2, " 1.6%	
Dependents who were wives or children of men who had served in the U. S. Army or Navy	1, " .8%	
Dependents who had relatives or friends willing to support them in their own homes	9, " 7.1%	
Dependents who had relatives not legally responsible but able to pay for their maintenance	2, " 1.6%	
Dependents who were able to work to earn their own support	4, " 3.1%	
	127, or 100.0%	
Total		241

TABLE XXXII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in May, 1912, and Found, After Investigation, to Fall Into Certain Groups.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the city.

Group II.

Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$766.00
Group II	42.77
Group III	706.47
Total	$1,515.24

TABLE XXXIII.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in May, 1912: for Those Found, After Investigation, to Fall into the Groups Shown; and for Those Who Could Not be Classified, but Who Would Have Fallen into These Groups on the Basis of the Proportions in Each Group of Those Classified.

Group I.
- Dependents who had legally responsible relatives able to pay for their maintenance.
- Dependents who were personally able to pay for their maintenance.
- Dependents who were aliens.
- Dependents who were non-residents of the City.

Group II.
- Dependents who had served in the U. S. Army or Navy.
- Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.
- Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
- Dependents who had relatives or friends willing to support them in their own homes.
- Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$1,619.44
Group II	90.42
Group III	1,493.59
Total	$3,203.45

LIST II.

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN DIVISION.

Readmissions Within 11 Months after the Date of the Letter of the Second Deputy Commissioner of Public Charities (see page 35) of Dependents Discharged from the Home for Transfer to New York City Farm Colony.

EXPLANATION OF ABBREVIATIONS:

C. of C.	Deputy Commissioner of Charities' Office in Brooklyn.
Hosp.	Kings County Hospital.
F.C.	Discharged for transfer to Farm Colony.
Ref. F.C.	Discharged for refusing transfer to Farm Colony.
On Reg.	Name of dependent on Register at this Home.
Own Req.	Discharge requested by dependent.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
2	May 13, 1912	C. of C.	May 25, 1912	Own Req.
56	July 15, 1912	C. of C.	July 16, 1912	Ref. F.C.
58	Oct. 19, 1911	C. of C.	Oct. 24, 1911	F.C.
61	Dec. 28, 1911	C. of C.	Jan. 4, 1912	F.C.
66	Oct. 10, 1911	C. of C.	Oct. 13, 1911	F.C.
69	Jan. 20, 1912	C. of C.	June 10, 1912	Own Req.
116	Dec. 22, 1911	C. of C.	Jan. 9, 1912	Own Req.
128	Nov. 18, 1911	C. of C.	Nov. 20, 1911	To C. of C.
"	Aug. 5, 1912	C. of C.	On Reg. Nov. 25, 1912	
141	Apr. 6, 1912	C. of C.	May 21, 1912	F.C.
163	May 10, 1912	C. of C.	May 20, 1912	Own Req.
169	Dec. 19, 1911	C. of C.	Dec. 21, 1911	F.C.
174	Apr. 25, 1912	C. of C.	Apr. 1, 1912	Own Req.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
177	Aug. 13, 1912	C. of C.	Aug. 15, 1912	F.C.
179	Nov. 18, 1911	C. of C.	Nov. 20, 1911	To C. of C.
182	Dec. 1, 1911	C. of C.	Dec. 12, 1911	F.C.
"	Dec. 20, 1911	C. of C.	Dec. 21, 1911	Ref. F.C.
"	Dec. 28, 1911	C. of C.	Dec. 29, 1911	To C. of C.
"	Jan. 3, 1912	C. of C.	Jan. 11, 1912	F.C.
"	Mar. 23, 1912	C. of C.	May 21, 1912	Ref. F.C.
"	July 19, 1912	C. of C.	July 24, 1912	Absconded
"	Aug. 7, 1912	C. of C.	Aug. 15, 1912	Ref. F.C.
187	Feb. 1, 1912	C. of C.	Apr. 4, 1912	Own Req.
198	Mar. 31, 1912	C. of C.	Apr. 26, 1912	Own Req.
"	May 30, 1912	C. of C.	June 3, 1912	Own Req.
"	June 12, 1912	C. of C.	June 17, 1912	Absconded
209	Apr. 15, 1912	C. of C.	May 21, 1912	F.C.
226	Feb. 14, 1912	C. of C.	Dec. 19, 1912	Own Req.
249	Aug. 28, 1912	C. of C.	On Reg. Nov. 25, 1912	
259	Nov. 27, 1911	C. of C.	Nov. 28, 1911	F.C.
262	Dec. 6, 1911	C. of C.	Dec. 7, 1911	Own Req.
"	Feb. 19, 1912	C. of C.	Feb. 21, 1912	Own Req.
"	Mar. 15, 1912	C. of C.	July 22, 1912	Own Req.
"	July 24, 1912	C. of C.	July 25, 1912	F.C.
"	July 29, 1912	C. of C.	July 31, 1912	Ref. F.C.
"	Aug. 5, 1912	C. of C.	On Reg. Nov. 25, 1912	
270	Apr. 14, 1912	C. of C.	July 24, 1912	Ref. F.C.
"	July 29, 1912	C. of C.	On Reg. Nov. 25, 1912	
272	Jan. 8, 1912	C. of C.	Apr. 8, 1912	Own Req.
"	June 11, 1912	C. of C.	On Reg. Nov. 25, 1912	
289	Dec. 15, 1911	C. of C.	Dec. 21, 1911	F.C.
"	Feb. 14, 1912	C. of C.	May 2, 1912	Own Req.
"	May 21, 1912	C. of C.	June 20, 1912	Own Req.
"	July 19, 1912	C. of C.	Aug. 6, 1912	Own Req.
"	Aug. 14, 1912	C. of C.	Aug. 15, 1912	Ref. F.C.
290	Nov. 9, 1911	C. of C.	Nov. 22, 1911	Own Req.
"	Jan. 17, 1912	C. of C.	Mar. 18, 1912	Own Req.
"	Mar. 25, 1912	C. of C.	June 5, 1912	Own Req.
"	June 10, 1912	C. of C.	July 1, 1912	Own Req.
291	Nov. 9, 1911	C. of C.	Dec. 4, 1911	Own Req.
"	Mar. 7, 1912	C. of C.	Mar. 18, 1912	Own Req.
"	Apr. 31, 1912	C. of C.	May 27, 1912	Own Req.
"	June 2, 1912	C. of C.	June 8, 1912	Own Req.
"	June 10, 1912	C. of C.	June 17, 1912	Own Req.
293	Nov. 21, 1911	C. of C.	Nov. 28, 1911	F.C.
"	Jan. 9, 1912	Hosp.	Jan. 11, 1912	F.C.
294	Oct. 16, 1911	Hosp.	Oct. 24, 1911	F.C.
301	Aug. 8, 1912	C. of C.	Aug. 8, 1912	Own Req.
307	Feb. 29, 1912	C. of C.	Mar. 2, 1912	Died
316	May 6, 1912	C. of C.	May 20, 1912	Own Req.
317	Nov. 21, 1911	C. of C.	Nov. 28, 1911	F.C.
322	July 15, 1912	C. of C.	July 16, 1912	F.C.
330	Jan. 18, 1912	C. of C.	July 16, 1912	F.C.
338	Mar. 20, 1912	C. of C.	July 22, 1912	Own Req.
351	May 15, 1912	C. of C.	Aug. 21, 1912	F.C.
354	Oct. 19, 1911	C. of C.	Feb. 19, 1912	Own Req.
"	Feb. 20, 1912	C. of C.	Apr. 19, 1912	Own Req.
"	May 3, 1912	C. of C.	May 27, 1912	Own Req.
"	May 31, 1912	C. of C.	July 2, 1912	Own Req.
"	July 5, 1912	C. of C.	Aug. 12, 1912	Own Req.
"	Aug. 19, 1912	C. of C.	On Reg. Nov. 25, 1912	
356	Nov. 11, 1911	C. of C.	On Reg. Nov. 25, 1912	
369	Nov. 20, 1911	C. of C.	May 6, 1912	Own Req.
"	May 30, 1912	C. of C.	July 16, 1912	F.C.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
373	Oct. 20, 1911	C. of C.	Oct. 23, 1911	Own Req.
381	Dec. 2, 1911	C. of C.	Dec. 12, 1911	F.C.
397	June 18, 1912	C. of C.	June 21, 1912	Own Req.
416	July 11, 1912	C. of C.	July 16, 1912	F.C.
435	Nov. 25, 1911	C. of C.	Feb. 4, 1912	Own Req.
439	July 31, 1912	C. of C.	Aug. 15, 1912	F.C.
442	Apr. 8, 1912	C. of C.	May 21, 1912	F.C.
446	Nov. 21, 1911	C. of C.	Nov. 23, 1911	Ref. F.C.
"	Apr. 5, 1912	C. of C.	Apr. 26, 1912	Own Req.
450	Dec. 4, 1911	C. of C.	Dec. 12, 1911	F.C.
482	Nov. 4, 1911	C. of C.	Nov. 9, 1911	F.C.
483	Nov. 17, 1911	C. of C.	Jan. 1, 1912	F.C.
499	July 24, 1912	C. of C.	July 25, 1912	Ref. F.C.
503	Mar. 20, 1912	C. of C.	Mar. 31, 1912	Absconded
"	Aug. 9, 1912	C. of C.	Aug. 15, 1912	F.C.
539	Dec. 1, 1911	C. of C.	Apr. 8, 1912	Own Req.
541	Dec. 30, 1911	Hosp.	Jan. 11, 1912	F.C.
545	Nov. 20, 1911	C. of C.	Nov. 28, 1911	F.C.
546	Nov. 22, 1911	C. of C.	Nov. 28, 1911	F.C.
"	Apr. 15, 1912	C. of C.	May 13, 1912	Own Req.
547	Nov. 14, 1911	C. of C.	Nov. 16, 1911	F.C.
549	Dec. 20, 1911	C. of C.	Dec. 21, 1911	Ref. F.C.
554	Dec. 8, 1911	C. of C.	Dec. 12, 1911	F.C.
561	Dec. 21, 1911	C. of C.	Dec. 22, 1911	Own Req.
571	Jan. 2, 1912	C. of C.	Jan. 4, 1912	F.C.
585	May 3, 1912	C. of C.	May 22, 1912	Own Req.
"	June 12, 1912	C. of C.	July 1, 1912	Own Req.
590	May 30, 1912	C. of C.	June 3, 1912	Own Req.
602	May 3, 1912	C. of C.	May 6, 1912	Own Req.
"	May 7, 1912	C. of C.	May 21, 1912	F.C.
605	May 27, 1912	C. of C.	June 24, 1912	Own Req.
636	May 27, 1912	C. of C.	Aug. 19, 1912	Died
647	Dec. 28, 1911	C. of C.	Dec. 28, 1911	To C. of C.
"	May 11, 1912	C. of C.	May 25, 1912	Own Req.
"	May 28, 1912	C. of C.	June 3, 1912	Own Req.
"	June 5, 1912	C. of C.	June 8, 1912	Own Req.
"	June 21, 1912	C. of C.	June 21, 1912	Own Req.
660	Oct. 11, 1911	C. of C.	Oct. 13, 1911	Ref. F.C.
"	Apr. 18, 1912	C. of C.	May 10, 1912	Own Req.
"	July 16, 1912	C. of C.	July 17, 1912	Own Req.
701	Aug. 16, 1912	C. of C.	On Reg. Nov. 25, 1912	
713	Mar. 25, 1912	C. of C.	Apr. 22, 1912	Own Req.
719	Mar. 20, 1912	C. of C.	Apr. 1, 1912	Own Req.
"	May 24, 1912	C. of C.	June 10, 1912	Own Req.
"	June 19, 1912	C. of C.	July 15, 1912	Ref. F.C.
"	July 20, 1912	C. of C.	Aug. 12, 1912	Own Req.
"	Aug. 16, 1912	C. of C.	Aug. 19, 1912	Ref. F.C.
722	Aug. 16, 1912	C. of C.	Aug. 19, 1912	Own Req.
732	Nov. 5, 1911	C. of C.	On Reg. Nov. 25, 1912	
734	Mar. 20, 1912	C. of C.	On Reg. Nov. 25, 1912	
753	Mar. 19, 1912	C. of C.	On Reg. Nov. 25, 1912	
772	Nov. 13, 1911	C. of C.	On Reg. Nov. 25, 1912	
773	July 5, 1912	C. of C.	On Reg. Nov. 25, 1912	
775	May 25, 1912	C. of C.	June 3, 1912	Own Req.
"	July 6, 1912	C. of C.	July 15, 1912	Own Req.
"	Aug. 6, 1912	C. of C.	On Reg. Nov. 25, 1912	
776	Oct. 28, 1911	C. of C.	Mar. 27, 1912	Own Req.
781	July 20, 1912	C. of C.	July 22, 1912	Own Req.
821	June 20, 1912	C. of C.	July 16, 1912	F.C.
822	Jan. 29, 1912	C. of C.	Feb. 27, 1912	Own Req.
"	May 4, 1912	C. of C.	May 21, 1912	F.C.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
828	Oct. 30, 1911	C. of C.	Oct. 31, 1911	To C. of C.
841	Nov. 15, 1911	C. of C.	Nov. 16, 1911	Own Req.
"	May 23, 1912	C. of C.	June 10, 1912	Own Req.
856	Apr. 4, 1912	C. of C.	Apr. 8, 1912	Own Req.
875	Feb. 20, 1912	C. of C.	Feb. 21, 1912	To C. of C.
"	May 20, 1912	C. of C.	June 11, 1912	Own Req.
885	Feb. 29, 1912	C. of C.	June 10, 1912	Own Req.
"	July 18, 1912	C. of C.	July 24, 1912	Ref. F.C.
896	Dec. 30, 1911	C. of C.	Jan. 4, 1912	F.C.
915	Apr. 26, 1912	C. of C.	May 2, 1912	Own Req.
"	June 21, 1912	C. of C.	On Reg. Nov. 25, 1912	
919	June 24, 1912	C. of C.	June 24, 1912	To C. of C.
923	Nov. 11, 1911	C. of C.	Dec. 22, 1911	Own Req.
925	June 20, 1912	C. of C.	June 28, 1912	Own Req.
"	July 8, 1912	C. of C.	July 16 1912	Ref. F.C.
926	June 26, 1912	C. of C.	July 8' 1912	Own Req.
927	Aug. 6, 1912	C. of C.	Aug. 7, 1912	Own Req.
928	July 23, 1912	C. of C.	July 25, 1912	F.C.
930	Mar. 14, 1912	C. of C.	Apr. 24, 1912	Own Req.
951	Aug. 26, 1912	C. of C.	Sept. 12, 1912	F.C.
959	Mar. 11, 1912	C. of C.	Mar. 17, 1912	Own Req.
962	Dec. 4, 1911	C. of C.	Dec. 21, 1911	F.C.
963	Nov. 3, 1911	C. of C.	Nov. 9, 1911	F.C.

LIST III.

New York City Home for the Aged and Infirm, Brooklyn Division.

Readmissions of Dependents Discharged for Refusing Transfer to Farm Colony after October 7, 1911.

Explanation of Abbreviations:

C. of C.	Deputy Commissioner of Charities' Office in Brooklyn.
Hosp.	Kings County Hospital.
F.C.	Discharged for transfer to Farm Colony.
Ref. F.C.	Discharged for refusing transfer to Farm Colony.
On Reg.	Name of dependent on Register at this Home.
Own Req.	Discharge requested by dependent.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
3	Oct. 28, 1911	C. of C.	Dec. 21, 1911	Ref. F.C.
"	May 30, 1912	Hosp.	July 17, 1912	Absconded
"	July 20, 1912	C. of C.	July 26, 1912	Absconded
"	July 26, 1912	C. of C.	Aug. 1, 1912	Absconded
"	Aug. 3, 1912	C. of C.	On Reg. Nov. 25, 1912	
7	June 21, 1912	C. of C.	June 28, 1912	Own Req.
"	July 8, 1912	C. of C.	July 16, 1912	Ref. F.C.
8	Oct. 23, 1911	C. of C.	Oct. 24, 1911	F.C.
"	Nov. 16, 1911	C. of C.	Nov. 17, 1911	To C. of C.
"	Dec. 6, 1911	C. of C.	Dec. 7, 1911	Own Req.
"	Feb. 19, 1912	Hosp.	Feb. 21, 1912	Own Req.
"	Mar. 15, 1912	C. of C.	July 22, 1912	Own Req.
"	July 24, 1912	C. of C.	July 25, 1912	F.C.
"	July 29, 1912	C. of C.	July 31, 1912	Ref. F.C.
"	Aug. 5, 1912	C. of C.	Nov. 25, 1912	Intoxication
11	Oct. 9, 1912	C. of C.	On Reg. Dec. 17, 1912	
22	Jan. 2, 1912	C. of C.	Jan. 4, 1912	Ref. F.C.

No. of Case	Date Readmitted	By Whom Readmitted	Date of Discharge	Cause of Discharge
26	Jan. 13, 1912	Hosp.	Mar. 25, 1912	Own Req.
"	Nov. 16, 1912	C. of C.	On Reg. Dec. 17, 1912	
28	Apr. 29, 1912	C. of C.	Aug. 28, 1912	Own Req.
30	Dec. 28, 1911	C. of C.	Dec. 29, 1911	To C. of C.
"	Jan. 3, 1912	C. of C.	Jan. 11, 1912	F.C.
"	Mar. 23, 1912	C. of C.	May 21, 1912	Ref. F.C.
"	July 19, 1912	C. of C.	July 24, 1912	Absconded
"	Aug. 7, 1912	C. of C.	Aug. 15, 1912	Ref. F.C.
32	Jan. 2, 1912	C. of C.	Jan. 4, 1912	F.C.
33	Feb. 21, 1912	C. of C.	On Reg. Aug. 8, 1912	
37	Jan. 22, 1912	C. of C.	On Reg. Dec. 17, 1912	
40	Dec. 30, 1911	C. of C.	Apr. 1, 1912	Own Req.
"	May 24, 1911	C. of C.	June 3, 1912	Own Req.
"	June 15, 1912	C. of C.	June 20, 1912	Own Req.
44	July 29, 1912	C. of C.	On Reg. Aug. 8, 1912	
46	June 18, 1912	C. of C.	On Reg. Aug. 8, 1912	
50	Dec. 4, 1911	Hosp.	Dec. 21, 1911	F.C.
57	Oct. 29, 1911	C. of C.	On Reg. Dec. 17, 1912	
59	Dec. 13, 1911	Hosp.	Dec. 21, 1911	F.C.
62	Dec. 18, 1911	C. of C.	Dec. 21, 1911	F.C.
"	Feb. 21, 1912	C. of C.	Feb. 27, 1912	Own Req.
"	Apr. 9, 1912	C. of C.	Apr. 15, 1912	Own Req.
67	July 25, 1912	C. of C.	July 25, 1912	F.C.
"	Nov. 18, 1912	C. of C.	On Reg. Dec. 17, 1912	
71	Aug. 20, 1912	Hosp.	On Reg. Nov. 25, 1912	
73	Apr. 12, 1912	C. of C.	Apr. 22, 1912	Own Req.
"	June 25, 1912	C. of C.	July 15, 1912	Own Req.
"	Aug. 27, 1912	C. of C.	Aug. 31, 1912	Own Req.
"	Sept. 18, 1912	C. of C.	Sept. 30, 1912	Own Req.
"	Nov. 11, 1912	C. of C.	Nov. 21, 1912	Ref. F.C.
79	Jan. 17, 1912	C. of C.	Mar. 25, 1912	Own Req.
88	Sept. 23, 1912	C. of C.	Sept. 24, 1912	F.C.
97	May 30, 1912	C. of C.	June 3, 1912	Own Req.
98	Dec. 20, 1911	Hosp.	Dec. 21, 1911	Ref. F.C.
108	Aug. 8, 1912	C. of C.	On Reg. Aug. 15, 1912	
115	Aug. 16, 1912	C. of C.	Aug. 19, 1912	Ref. F.C.
121	Aug. 11, 1912	Hosp.	Oct. 3, 1912	Ward 33, Hosp.
125	Oct. 28, 1911	C. of C.	Mar. 27, 1912	Own Req.
129	Aug. 6, 1912	C. of C.	On Reg. Nov. 25, 1912	
135	July 3, 1912	C. of C.	July 13, 1912	Own Req.
"	July 22, 1912	C. of C.	July 25, 1912	Ref. F.C.
150	Aug. 13, 1912	C. of C.	Aug. 14, 1912	Ref. F.C.
154	Aug. 13, 1912	C. of C.	On Reg. Aug. 15, 1912	
160	Nov. 11, 1911	C. of C.	Nov. 14, 1911	Absconded
"	Jan. 7, 1912	C. of C.	On Reg. Dec. 17, 1912	
161	July 6, 1912	C. of C.	On Reg. Aug. 15, 1912	
162	Mar. 19, 1912	C. of C.	Apr. 11, 1912	Own Req.
"	Apr. 18, 1912	C. of C.	May 10, 1912	Own Req.
"	July 16, 1912	C. of C.	July 17, 1912	Ward 43, Hosp.
"	Sept. 26, 1912	C. of C.	Oct. 31, 1912	F.C.
163	Feb. 9, 1912	C. of C.	Mar. 18, 1912	Own Req.
"	May 22, 1912	C. of C.	May 25, 1912	Own Req.
"	July 18, 1912	C. of C.	July 24, 1912	Ref. F.C.
"	Aug. 27, 1912	C. of C.	Aug. 30, 1912	Own Req.
"	Sept. 8, 1912	C. of C.	Sept. 23, 1912	Own Req.
"	Sept. 30, 1912	C. of C.	Oct. 15, 1912	Absconded
"	Nov. 6, 1912	C. of C.	Nov. 14, 1912	Absconded
"	Dec. 5, 1912	C. of C.	Dec. 16, 1912	Absconded
168	Dec. 23, 1911	C. of C.	Dec. 26, 1911	Died
170	Dec. 2, 1912	C. of C.	On Reg. Dec. 17, 1912	

TABLE XXXIV.

NEW YORK CITY FARM COLONY.

Admissions from July 1, 1911, to June 30, 1912.

Sources	Borough of Manhattan	Mt. Vernon, N. Y. B. D. A. Manhattan	City Home, Manhattan	Metropolitan Hospital	City Hospital	Municipal Lodging House	Randall's Island	Borough of Brooklyn	City Home, Brooklyn	Raymond St. Hospital, Brooklyn	Borough of Richmond	S. R. Smith Infirmary	House of Divine Providence	Suspected Insane	By Order of Supt. of Farm Colony	N. Y. City Farm Colony Employees	Readmitted to Correct Census	Total
1911																		
July	17	..	5	..	..	4	1	1	101	..	13	2	..	1	..	..	..	145
August	20	..	3	..	..	..	..	1	33	..	16	..	..	..	..	..	..	73
September	10	..	..	..	..	..	1	2	27	..	5	2	..	1	..	..	..	48
Total 3d Quarter	47	..	8	..	..	4	2	4	161	..	34	4	..	2	..	..	..	266
October	43	1	27	..	..	..	..	8	68	1	20	1	..	..	..	..	7	176
November	49	..	3	..	..	1	..	6	76	..	12	..	..	..	..	..	7	154
December	38	..	3	..	..	35	..	4	50	..	10	3	..	..	..	..	2	145
Total 4th Quarter	130	1	33	..	..	36	..	18	194	1	42	4	..	..	..	..	16	475
1912																		
January	55	..	1	..	..	..	..	2	50	..	7	..	..	..	..	..	..	115
February	23	..	49	..	..	..	..	2	..	..	9	2	..	..	..	2	..	87
March	7	..	1	..	..	..	..	..	..	..	5	..	..	3	3	..	..	19
Total 1st Quarter	85	..	51	..	..	..	..	4	50	..	21	2	..	3	3	2	..	221
April	16	..	42	..	1	..	..	..	..	..	2	..	..	5	..	..	..	66
May	38	..	18	2	..	..	..	..	15	..	11	..	1	7	6	..	..	98
June	49	..	110	1	2	..	..	..	..	..	8	..	..	3	12	..	..	185
Total 2d Quarter	103	...	170	3	3	..	..	..	15	..	21	..	1	15	18	..	..	349
Total	365	1	262	3	3	40	2	26	420	1	118	10	1	20	21	2	16	1,311

TABLE XXXV.

New York City Farm Colony.

This Table is a Copy of the Farm Colony Records, with Footings and Percentages Added by the Investigators.

Causes for Admission July 1, 1911, to May 31, 1912.

	Out of Work		Sickness		Old Age		Epileptic		Insane		Crippled		Suspected Insane		Total
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
July	45	1	15	5	24	3	2	1	2	3	44	..	..	..	145 (1 M. Ch'd)
August	24	1	5	2	13	3	..	..	..	..	18	..	3	3	72
September	23	3	7	..	4	1	..	..	2	2	4	1	1	..	48
October	86	4	30	1	15	1	4	1	2	5	22	4	1	..	176
November	57	2	28	4	28	3	..	..	1	1	29	1	..	..	154
December	83	1	26	3	15	2	3	..	5	1	9	.	..	..	148
January	72	1	20	2	2	1	..	..	..	1	14	1	1	..	115
February	32	2	18	1	18	..	..	..	..	1	14	..	1	..	87
March	5	3	3	2	1	1	..	..	3	1	..	..	..	..	19
April	24	4	8	1	13	2	..	..	3	1	10	..	..	..	66
May	32	3	7	1	21	3	..	..	6	2	21	1	..	1	98
	483	25	167	22	154	20	9	2	24	18	185	8	7	4	1,128
	45.0%		16.8%		15.4%		1.0%		3.7%		17.1%		1.0%		100.0%

Note: There are two errors in this tabulation, there being one dependent too few in August and three too many in December, making an excess of two dependents in the eleven months. The latter error was corrected on the Colony census records after attention was called to it.

TABLE XXXVI.

New York City Farm Colony.

Authorizations for Admission Found on File at the Colony for the 98 Admissions in May, 1912.

Admissions Having Authorizations at the Colony from the Bureaus of Dependent Adults		82
Permits from the Bureau of Dependent Adults, Manhattan	56	
Permits bearing the name of a clerk in the Bureau of Dependent Adults, Brooklyn	15	
Permits from the Bureau of Dependent Adults, Richmond	11	
	82	
Admissions Not Having Authorizations at the Home from the Bureaus of Dependent Adults		16
Commitments by magistrates for observation as to sanity with commitment papers on file at the Colony	7	
Commitment by magistrates for observation with no commitment papers found on file	1	
Admissions from the House of Divine Providence, S. I., for whom no permits were found on file	1	
Admissions of former inmates of the Colony for whom no permits were found on file	2	
Admissions of former inmates of municipal institutions for whom no permits were found on file	2	
Admissions entered on books to correct previous alleged erroneous entries of discharge	3	
	16	
Total		98

TABLE XXXVII.

NEW YORK CITY FARM COLONY.

Findings, After Investigation, Regarding the Residence Addresses of 91 Dependents Entered upon the Records of Admission to the Colony in May, 1912.

Residences of dependents just prior to admission	13, or 14.3%
Residences of dependents at some time before admission	8, " 8.8%
Addresses where dependents were not known	35, " 38.4%
Addresses of lodging houses	12, " 13.2%
Addresses that were not residential	2, " 2.2%
Addresses that were not sufficiently explicit for investigation	12, " 13.2%
Addresses that were outside of the City	2, " 2.2%
Dependents admitted without residential addresses	7, " 7.7%
Total	91, or 100.0%

TABLE XXXVIII.

NEW YORK CITY FARM COLONY.

Findings, After Investigation, Regarding the Residence Addresses of 90 Relatives and Friends of Dependents Entered upon the Records of Admission in May, 1912.

Residences of relatives or friends just prior to the admission	24, or 26.7%
Residences of relatives or friends at some time before the admission	5, " 5.6%
Addresses where relatives or friends were not known	32, " 35.5%
Addresses of lodging houses	3, " 3.3%
Addresses that were not residential	9, " 10.0%
Addresses that were not sufficiently explicit for investigation	8, " 8.9%
Addresses that were outside of the City	9, " 10.0%
Total	90, or 100.0%

NOTE: The records for 19 admissions during this month had no names and addresses of relatives or friends entered upon them.

TABLE XXXIX.

NEW YORK CITY FARM COLONY.

Findings, After Investigation, Regarding the Residence Addresses of 109 Dependents Entered upon the Records of Admission to the Colony in December, 1911.

Residences of dependents just prior to admission	9, or 8.2%
Residences of dependents at some time before admission	1, " .9%
Addresses where dependents were not known	8, " 7.8%
Addresses of lodging houses	13, " 12.0%
Addresses that were not residential	5, " 4.6%
Addresses that were not sufficiently explicit for investigation	7, " 6.4%
Addresses that were outside of the City	1, " .9%
Dependents admitted without residential addresses	65, " 59.7%
Total	109, or 100.0%

TABLE XL.

NEW YORK CITY FARM COLONY.

Findings, After Investigation, Regarding the Residence Addresses of 67 Relatives and Friends of Dependents Entered upon the Records of Admission in December, 1911.

Residences of relatives or friends just prior to the admission	22, or 32.8%
Residences of relatives or friends at some time before the admission	1, " 1.4%
Addresses where relatives or friends were not known	15, " 22.4%
Addresses of lodging houses	3, " 4.5%
Addresses that were not residential	6, " 9.0%
Addresses that were not sufficiently explicit for investigation	5, " 7.5%
Addresses that were outside of the City	15, " 22.4%
Total	67, or 100.0%

NOTE: The records for 34 admissions during this month had no names and addresses of relatives or friends entered upon them.

TABLE XLI.

NEW YORK CITY FARM COLONY.

Findings, After Investigation, Regarding the Character of the 98 Dependents Admitted in May, 1912.

ADMISSIONS THAT COULD NOT BE CLASSIFIED AS TO CHARACTER FOR THE FOLLOWING REASONS:		51
The addresses found at the Colony were insufficient in	13 Cases	
The dependents were unknown at the addresses given in	31 "	
The addresses given were too old in	3 "	
Sufficiently complete histories could not be secured in	4 "	
	51 Cases	
ADMISSIONS CLASSIFIED AS TO CHARACTER:		47
Dependents who seemed to have had a legitimate claim upon the City's support	17, or 36.2%	
Dependents who were aliens	16, " 34.0%	
Dependents alleged to have been insane	7, " 15.0%	
Dependents who had legally responsible relatives able to pay for their maintenance	1, " 2.1%	
Dependents who were personally able to pay for their maintenance	1, " 2.1%	
Dependents who had served in the U. S. Army or Navy	1, " 2.1%	
Dependents who had relatives willing to support them in their own homes	1, " 2.1%	
Dependents who had relatives not legally responsible but able to pay for their maintenance	2, " 4.3%	
Dependents who were able to work to earn their own support	1, " 2.1%	
	47, or 100.0%	
Total		98

TABLE XLII.

NEW YORK CITY FARM COLONY.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in May, 1912, and Found, After Investigation, to Fall into Certain Groups.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.

Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$808.48
Group II	123.49
Group III	213.15
Total	$1,145.12

TABLE XLIII.

New York City Farm Colony.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in May, 1912: for Those Found, After Investigation, to Fall into the Groups Shown; and for Those Who Could Not be Classified, but Who Would Have Fallen into These Groups on the Basis of the Proportions in Each Group of Those Classified.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.

Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$1,755.79
Group II	165.82
Group III	447.62
Total	$2,369.23

TABLE XLIV.

New York City Farm Colony.

Findings, After Investigation, Regarding the Character of 90 Dependents Admitted in December, 1911.

Admissions That Could Not be Classified as to Character for the Following Reasons:		55
The addresses at the Colony were insufficient in	23 Cases	
The dependents were unknown at the addresses given in	27 "	
Sufficiently complete histories could not be secured in	5 "	
	55 Cases	
Admissions Classified as to Character:		35
Dependents who seemed to have had a legitimate claim upon the City's support	10, or 28.6%	
Dependents who were aliens	17, " 48.6%	
Dependents who had legally responsible relatives able to pay for their maintenance	4, " 11.5%	
Dependents who were personally able to pay for their maintenance	2, " 5.7%	
Dependents who had relatives willing to support them in their own homes	1, " 2.8%	
Dependents who were able to work to earn their own support	1, " 2.8%	
	35, or 100.0%	
Total		90

TABLE XLV.

New York City Farm Colony.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in December, 1911, and Found, After Investigation, to Fall into Certain Groups.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$2,590.62
Group III	74.65
Total	$2,674.27

TABLE XLVI.

New York City Farm Colony.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in December, 1911: for Those Found, After Investigation, to Fall into the Groups Shown; and for Those Who Could Not be Classified, but Who Would have Fallen into These Groups on the Basis of the Proportions in Each Group of Those Classified.

Group I.

Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group III.

Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Estimated Expense:

Group I	$10,956.50
Group III	314.62
Total	$11,271.12

TABLE XLVII.

Admissions to Almshouses of New York.

Authorizations for Admission Found on File at the Almshouses for the 592 Admissions in May, 1912.

Admissions Having Authorizations at the Almshouses from the Bureaus of Dependent Adults		507
Permits bearing the name of a Superintendent of a Bureau of Dependent Adults	208	
Permits bearing the name of the Examining Physician	102	
Permits bearing the name of a clerk in the Bureau of Dependent Adults, Brooklyn	197	
	507	
Admissions Not Having Authorizations at the Almshouses from the Bureaus of Dependent Adults		85
Transfer slips bearing the name of the Superintendent of Kings County Hospital	56	
Admission slips bearing the names of doctors at municipal hospitals	8	
Commitments by magistrates with papers on file	7	
Commitments by magistrates with no papers on file	1	
Admission slips to City Home, Manhattan, bearing the name of the Superintendent of Farm Colony	1	
Admissions entered for which there were no permits or slips on file	12	
Total	85	592

TABLE XLVIII.

Admissions to Almshouses of New York.

Findings, After Investigation, Regarding the Character of 868 Dependents Admitted During Certain Periods

New York City Home for the Aged and Infirm, Manhattan Division, December, 1911 (Males)	186
New York City Home for the Aged and Infirm, Manhattan Division, May, 1912 (Males)	253
New York City Home for the Aged and Infirm, Brooklyn Division, May, 1912	241
New York City Farm Colony, December, 1911	90
New York City Farm Colony, May, 1912	98
Total	868

Admissions That Could Not be Classified as to Character for the Following Reasons:

The addresses found at the almshouses were insufficient in	107 Cases
The dependents were unknown at the addresses given in	219 "
The addresses given were too old in	19 "
Sufficiently complete histories could not be secured in	61 "
	406 Cases

Admissions Classified as to Character:

Dependents who seemed to have had a legitimate claim upon the City's support	230, or 49.8%
Dependents who were aliens	125, " 27.0%
Dependents who had legally responsible relatives able to pay for their maintenance	34, " 7.4%
Dependents who did not have a legal settlement in New York City	17, " 3.7%
Dependents who had relatives or friends willing to support them in their own homes	14, " 3.0%
Dependents who were able to work to earn their own support	11, " 2.4%
Dependents who were personally able to pay for their maintenance	9, " 2.0%
Dependents who had served in the U. S. Army or Navy, or who were widows of men who had served in the U. S. Army or Navy	7, " 1.5%
Dependents who were alleged to be insane	7, " 1.5%
Dependents who had relatives not legally responsible but able to pay for their maintenance	8, " 1.7%
Total	462, or 100.0%

TABLE XLIX.

ADMISSIONS TO ALMSHOUSES OF NEW YORK.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in Two Months and Found, After Investigation, to Fall into Certain Groups.

Group I.
Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.
Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.
Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Institution	Admitted	Group I	Group II	Group III	Total
City Home, Manhattan.	Dec. 1911	$5,363.11	$235.59	$102.48	$5,701.28
" " "	May, 1912	3,793.72	1,579.94	485.52	5,859.18
" " Brooklyn..	May, 1912	766.00	42.77	706.47	1,515.24
Farm Colony.....	Dec., 1911	2,599.62	.....	74.65	2,674.27
" "	May, 1912	808.48	123.49	213.15	1,145.12
Total.....		$13,330.93	$1,981.89	$1,582.27	$16,895.09

TABLE L.

ADMISSIONS TO ALMSHOUSES OF NEW YORK.

Estimate of Expense to the City of the Maintenance of Dependents Admitted in Two Months: for Those Found, After Investigation, to Fall into the Groups Shown; and for Those Who Could Not be Classified, but Who Would Have Fallen into These Groups on the Basis of the Proportions in Each Group of Those Classified.

Group I.
Dependents who had legally responsible relatives able to pay for their maintenance.
Dependents who were personally able to pay for their maintenance.
Dependents who were aliens.
Dependents who were non-residents of the City.

Group II.
Dependents who had served in the U. S. Army or Navy.
Dependents who were wives or children of men who had served in the U. S. Army or Navy.

Group III.
Dependents who had relatives not legally responsible for their support but able to pay for their maintenance.
Dependents who had relatives or friends willing to support them in their own homes.
Dependents who were able to work to earn their own support.

Institution	Admitted	Group I	Group II	Group III	Total
City Home, Manhattan.	Dec., 1911	$10,726.22	$471.38	$204.96	$11,402.56
" " "	May, 1912	5,774.30	2,404.78	739.00	8,918.08
" " Brooklyn..	May, 1912	1,619.44	90.42	1,493.59	3,203.45
Farm Colony.....	Dec., 1911	10,956.50	.....	314.62	11,271.12
" "	May, 1912	1,755.79	165.82	447.62	2,369.23
Total.....		$30,832.25	$3,132.40	$3,199.79	$37,164.44

APPENDIX

TO

ADMISSIONS TO CITY HOMES (ALMSHOUSES)

Extracts from Information Gathered Regarding Some Dependents Admitted to the City Homes in December, 1911, and May, 1912

The first paragraph in each of the following brief digests states the nationality, age, and occupation of the dependent.

The second paragraph gives a summary of the findings of the investigators of the Committee, which determined the classification of the dependent.

Case 1. A native of Russia. Age 27. Occupation, laborer.

An alien who had been in the country only 4 months. The Home records also showed that he was in good physical condition and able to work. At the time of investigation it was found that the dependent had been sent back to Russia by the State Board of Charities.

Case 2. A native of Ireland. Age 76. Occupation, upholsterer.

The Home records showed that this dependent was an unnaturalized alien. He was without relatives in the United States.

Case 3. A native of Germany. Age 70. Occupation, gardener.

At the time of investigation it was found that this dependent was an unnaturalized alien, and had come from New Jersey only 8 days before admission.

Case 4. A native of the United States. Age 20. Occupation, printer.

This dependent was a non-resident. The Home records also showed him to be in good physical condition and able to work. At the time of investigation the State Board of Charities was found to have sent the dependent to a relative in Ohio.

Case 5. A native of Switzerland. Age 56. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. At the time of investigation the dependent was unknown at the address given.

Case 6. A native of Roumania. Age 70. Occupation, cutter.

The dependent's daughter said that her father lived with her but that when he became sick her husband would not let her continue the care of him. The dependent then went to live with his son, who kept him about 2 weeks and then turned him out. The daughter lived in a very good apartment. She said that her brother was a travelling man, who earned a good salary but would do nothing for his father. The dependent was said to be sleeping in a barber shop. The Home records showed that this dependent had been in the United States only 5 years and was not a citizen. The case was referred to the State Board of Charities, but was discharged by them without any action having been taken.

Case 7. A native of Ireland. Age 35. Occupation, laborer.

The Home records showed that this dependent had been in the United States only 11 days, and that he was in good physical condition and able to work. Investigation discovered that the State Board of Charities had sent him back to Ireland.

Case 8. A native of Scotland. Age 62. Occupation, waiter.

The investigator was unable to locate the inmate at the address given. The Home records showed that he was an alien, with 7 admissions to the institution.

Case 9. A native of Scotland. Age 62. Occupation, shoemaker.

The Colony records showed that this dependent was an unnaturalized alien.

CASE 10. A native of the United States. Age 53. Occupation, housekeeper.

At the time of investigation it was found that this dependent had children who were able and willing to pay for her maintenance.

CASE 11. A native of Germany. Age 63. Occupation, druggist.

The Home records showed that this dependent was an unnaturalized alien. There was no such number on the street as was given for the address of the dependent's friend on the Home records.

CASE 12. A native of Germany. Age 63. Occupation, druggist.

The Home records showed that this dependent was an unnaturalized alien.

CASE 13. A native of the United States. Age 52. Occupation, laborer.

The Colony records showed that this dependent was physically able to work but that he was admitted because he was out of employment. He has a stepmother well able to care for him.

CASE 14. A native of Austria. Age 40.

This dependent had been in this country about 5 years. His landlady said he had left the Home to go to work and was now out peddling. She also stated that he had just taken out his first papers and was not yet a citizen.

CASE 15. A native of France. Age 66. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien, and had been admitted 21 times to this Home alone.

CASE 16. A native of Ireland. Age 65. Occupation, musician.

The Home records showed that the dependent was an unnaturalized alien, and that he was in good physical condition.

CASE 17. A native of Ireland. Age 58. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. They also showed that he was in good physical condition and able to work but without friends in the United States. The investigator found that the dependent was unknown at the address he gave.

CASE 18. A native of Ireland. Age 80. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien, and that he became insane after this admission.

CASE 19. A native of Germany. Age 62. Occupation, painter.

A friend said that this dependent was able and willing to work but that he could not find employment. She was willing to take care of him, but rather than give her the expense the dependent went to the Home.

CASE 20. A native of the United States. Age 53. Occupation, canvasser.

The Home records showed that this dependent had been in the state only 7 months. At the time of investigation he was in Ohio, where he was being cared for by his brother.

CASE 21. A native of Germany. Age 77. Occupation, weaver.

This dependent's daughter said that he had a son, a school janitor, earning a very good salary. This son was found willing to pay $8 per month for his father's maintenance. The dependent had another son, a property owner in New Jersey.

CASE 22. A native of the United States. Age 48. Occupation, upholsterer.

This dependent was able to work, but was out of employment at the time of admission. When investigated it was found that this dependent's children were able to support their father, but were unwilling, as he was quite able to support himself.

CASE 23. A native of Germany. Age 61. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien.

CASE 24. A native of Roumania. Age 69. Occupation, druggist.

This dependent owned and operated a drug store. A friend claiming to have known him for 11 years said that the dependent's wife and family live in Vienna,

with the exception of 1 son, who lives somewhere in New England and earns about $35 per week. The dependent had called in a private physician for medical attention.

CASE 25. A native of Germany. Age 60. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. No address was given for himself or friends.

CASE 26. A native of France. Age 66. Occupation, hostler.

The Colony records showed that this dependent was an unnaturalized alien. The investigators found that both the dependent and friends were unknown at the address given.

CASE 27. A native of Ireland. Age 49. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. The dependent was unknown at the address given.

CASE 28. A native of Ireland. Age 53. Occupation, plasterer.

The Home records showed that this dependent was an unnaturalized alien, and also a cripple.

CASE 29. A native of Russia. Age 30. Occupation, furrier.

This case was referred to the State Board of Charities, and the dependent was returned to Russia by the Board. The entry on his history at the Home was that he had been in the United States only 8 months.

CASE 30. A native of Germany. Age 63. Occupation, tailor.

When investigated it was learned from a relative that this dependent had a sister who was in good circumstances, but did nothing for her brother.

CASE 31. A native of Germany. Age 63. Occupation, druggist.

The Home records showed that this dependent was an unnaturalized alien.

CASE 32. A native of Germany. Age 67. Occupation, clothes cleaner.

A widower. The Home records showed that he was an unnaturalized alien. The investigator was unable to locate him at the address given.

CASE 33. A native of Ireland. Age 62. Occupation, mason.

The Home records showed that the dependent was able to work when he entered the Home. The dependent died. He was insured for $200, but had no dependent relatives.

CASE 34. A native of Norway. Age 64 or over. Occupation, longshoreman.

This dependent said he had 3 sons—2 in business here, and 1 in Norway—and had received money from them. He thought they were able to support him.

CASE 35. A native of Italy. Age 22. Occupation, laborer.

An alien, who had lived 1 year in the United States but had not taken out his papers, according to the Home records. The friends were not known at the addresses given.

CASE 36. A native of Germany. Age 38. Occupation, cook.

According to the Colony records this dependent was an alien who had been in the United States only 2½ years, and in New York State only 1 week. The records showed that he was admitted because he was out of employment at the time, and was placed on the payroll of the Colony.

CASE 37. A native of Ireland. Age 21. Occupation, laborer.

The Home records showed that this dependent was an alien, only 6 weeks in the United States. They also showed that he was in good condition and able to work. The investigator discovered that the United States Government had returned him to Ireland.

CASE 38. A native of the United States. Age 73. Occupation, laborer.

The Home records showed that this dependent was a veteran, and was not married.

CASE 39. A native of Newfoundland. Age 65. Occupation, cook.

The Colony records showed that this dependent was an unnaturalized alien. He was also shown to be able to work but that he was admitted because he was out of employment.

CASE 40. A native of Ireland. Age 22. Occupation, laborer.

According to the Colony records this dependent was an alien, having been in the United States but 1 year.

CASE 41. A native of Ireland. Age 69. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. His landlady thought that he was a resident of New Jersey, where he was found to have gone, and where his brother lived.

CASE 42. A native of the United States. Age 60. Occupation, laborer.

A daughter of this dependent said that her father had been drinking and went to the Home without the knowledge of the family. The dependent had 2 sons and 1 daughter, and, when investigated, it was found that they had taken him out of the Home and were supporting him.

CASE 43. A native of Ireland. Age 46. Occupation, mason.

His wife said that she and her husband were living with their son, who was a mason, earning $5.60 a day. The family occupied a nice house. Another son earned $4 a day.

CASE 44. A native of Hungary. Age 22. Occupation, painter.

The Home records showed that this dependent was an unnaturalized alien. They also showed that he was in good physical condition and able to work. Investigation developed the fact that he had been deported to Hungary.

CASE 45. A native of England. Age 50. Occupation, dishwasher.

The Home records showed that this dependent was an unnaturalized alien. They also showed that he was in good physical condition and able to work. At the time of investigation he was working and had left the Home for that purpose.

CASE 46. A native of Germany. Age 56 or over. Occupation, tailor.

The Colony records showed that this dependent was an unnaturalized alien. At the time of investigation it was found that the dependent and his brother and sister were all unknown at the addresses given.

CASE 47. A native of Ireland. Age 28. Occupation, laborer.

The Home records showed that he had had only 7 months residence in the country and 5 months in the City. The case was referred to the State Board of Charities and the dependent discharged, as ordered by them, into the custody of his sister.

CASE 48. A native of Ireland. Age 54. Occupation, watchman.

The Home records showed that this dependent was an unnaturalized alien. They also showed him to be in good physical condition and able to work.

CASE 49. A native of the United States. Age 60. Occupation, gardener.

The investigator was unable to locate the dependent at the address given. An acquaintance was seen who stated that the dependent was then employed as an orderly in a municipal hospital. The patient had been employed by him on several occasions. He had relatives living in Connecticut. The informant would not say that they were able to maintain the dependent, but the dependent was able to work and maintain himself. Information was received from another source that the dependent had a sister living in Europe who made monthly remittances to him.

CASE 50. A native of the United States. Age 36. Occupation, chauffeur.

The mother stated that the dependent had a brother, a chauffeur, who owned his own business.

CASE 51. A native of Italy. Age 70. Occupation, tailor.

The Home records showed that this dependent was an unnaturalized alien. At the time of investigation it was discovered that a relative, after some difficulty, had located the dependent at the Home and had removed him to support him at his own home.

CASE 52. A native of Ireland. Age 70. Occupation, plasterer.

A sister said that the dependent's children were able and willing to care for their father if he would live a decent life. The dependent had 3 sons and 4 daughters.

CASE 53. A native of the United States. Age 54 or over. Occupation, driver.

The dependent's niece stated that he was strong and healthy, and well able to work. He had lived with her almost all his life, but drank periodically, and then became objectionable. If he would behave properly she would be willing to take him back and give him a home. The entries at the Home showed the dependent to have been admitted there 7 times.

CASE 54. A native of Greece. Age 15.

This case was referred to the Federal Government by the State Board of Charities, but no action was taken by the Government for 3 months. Then the dependent was sent to Chicago, Ill., at his own expense.

CASE 55. A native of Ireland. Age 55. Occupation, fireman.

The Home records showed that this dependent was an unnaturalized alien. His wife said that he was well and able to work, and that he went to the Home because she would not allow his children to support him. He was found working and giving $7 a week toward the support of the family. He also had 3 children earning wages.

CASE 56. A native of Italy. Age 51. Occupation, storekeeper.

A widower. The Home records showed that the dependent was an unnaturalized alien. The janitress at the address given stated that the dependent had returned to Italy.

CASE 57. A native of Ireland. Age 69. Occupation, gardener.

The Colony records showed that this dependent was an unnaturalized alien. When investigated the dependent's relative was unknown at the address given.

CASE 58. A German. Age 72. Formerly an engraver by occupation.

His 2 daughters had paid his board at a boarding-house. These daughters were employed and earned good wages, and they had been very prompt in paying their father's board.

CASE 59. A native of the United States. Age 28. Occupation, peddler.

A non-resident who, according to Home records, had been in New York City only 6 months. Investigation showed that the State Board of Charities had sent him to New Jersey at his own expense.

CASE 60. A native of the United States. Age 45. Occupation, cook.

According to the Colony records this dependent was in good condition and able to work but had been out of employment before the time of admission. At the time of investigation the dependent had a position and looked well.

CASE 61. A native of Ireland. Age 52 or over. Occupation, stableman.

The Colony records showed that this dependent was an unnaturalized alien. The records also showed him to be in good physical condition, able to work, but out of employment. He had no relatives in this country.

CASE 62. A native of Germany. Age 63. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. The investigator found no such place as the address given.

CASE 63. A native of Austria. Age 66. Occupation, weaver.

The Colony records showed that this dependent was an unnaturalized alien. The records also showed him to be in good condition and able to work, but that he was out of employment at the time of admission. The dependent was unknown at the address given, and without relatives or friends in the United States.

CASE 64. A native of Ireland. Age 55. Occupation, laborer.

According to the Colony records this dependent was able to work, but he was out of employment at the time of admission. When investigated it was found that the dependent might have a home with his wife and children if he wished it.

CASE 65. A native of the United States. Age 50. Occupation, proofreader.

A sister-in-law said that the dependent's 3 children were in good circumstances but had refused to support him.

CASE 66. A native of Ireland. Age 68. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien.

CASE 67. A native of the United States. Age 72. Occupation, furrier.

This dependent was a non-resident of New York City. The Home records showed him to be in good physical condition. Investigation showed that he came to New York expecting to find relatives, and, not finding them, went to the Home. He was sent to Illinois by the State Board of Charities.

CASE 68. A native of Germany. Age 70.

A citizen of the United States. He was an inmate of the Home 3 days preceding his death. The investigator talked with his son, who had paid $1.40 per day for 3 days, a total of $4.50, to the cashier at the Bureau of Dependent Adults for his father's maintenance in the Home.

CASE 69. A native of Ireland. Age 55 or over. Occupation, laborer.

A friend said that this dependent had 3 sons, who were well able to support their father, and a well-to-do sister in Ireland. At the time of the investigation the dependent was found to have secured a position.

CASE 70. A native of Italy. Age 67. Occupation, confectioner.

The Home records showed that this dependent was an unnaturalized alien. He was found living at home, with a daughter and 2 unmarried sons, both of whom earned wages. The dependent left the Home because he was tired of it.

CASE 71. A native of Ireland. Age 29. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. The records also showed that he was in good physical condition but that he was admitted because he was out of employment at the time. He had no relatives in United States.

CASE 72. A native of Ireland. Age 54 or over. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. The dependent and his friend were both unknown at the address given.

CASE 73. A native of Germany. Age 67. Occupation, bookbinder.

The Colony records showed that this dependent was an unnaturalized alien. He was without relatives or friends in the United States.

CASE 74. A native of Germany. Age 68. Occupation, janitor.

One daughter said that her father was sent to a municipal hospital, and was transferred to the Home without her consent or knowledge. She would have given him a home. A wife of 1 of the 2 sons said that her husband had given the dependent a home for years, and offered to take him out of the Home.

CASE 75. A native of Scotland. Age 60.

A childless widow. Her residence could not be located at the address given, it being that of a vacant lot. However, a cousin, an elderly woman, apparently in prosperous circumstances, stated that the inmate was the daughter of a very wealthy man, one of the richest in Scotland. Her cousin and her daughters united in saying that they were anxious to give the dependent a home, and requested the investigator to find out where she was, so that they could bring her to live with them.

CASE 76. A native of Germany. Age 59. Occupation, furrier.

The Colony records showed that this dependent was an unnaturalized alien. When investigated it was found that the dependent was unknown at the address given.

CASE 77. A native of Germany. Age 72. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien and that he was without relatives or friends in the United States.

CASE 78. A native of Germany. Age 46. Occupation, tailor.

The Home records showed that this dependent was an unnaturalized alien. He had a wife and 2 daughters living in a very comfortable apartment house, and the janitress said she thought both the wife and 1 of the 2 daughters were working.

CASE 79. Born in Italy. Age 66 years. Occupation, laborer.

The dependent's sister-in-law stated that the dependent had a bank account in the Dime Savings Bank, with about $200 to his credit. He had been an undertaker and at one time had a great deal of money.

CASE 80. A native of Ireland. Age 64. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien, who had lived only 3 months in New York State. They showed him to have been in good physical condition. At the time of investigation it was found that he had been sent to Massachusetts by the State Board of Charities.

CASE 81. A native of the United States. Age 47. Occupation, ironworker.

The investigator found that the dependent was a non-resident, and that he had been sent to Massachusetts by the State Board of Charities.

CASE 82. A native of Italy. Age 76.

In the country 20 years, but not a citizen. His cousin was interviewed, and said that the old man had lived at their home for a long time but that they "got tired of keeping him" and sent him to the Brooklyn Home. He had been transferred to the Colony. These people owned a good barber shop but would pay nothing for his support. The Department of State and Alien Poor, of the State Board of Charities, had no record of any request for the investigation of this alien for possible deportation.

CASE 83. A native of the United States. Age 49. Occupation, laborer.

The dependent had been in the Home 13 times, although in 1901 a note was entered on the history of this dependent that he was not to be readmitted. The dependent's sister-in-law was interviewed. She said that his 4 brothers were all able to take care of him, and if they would do their share in clothing him she would be willing to maintain him in her own home.

CASE 84. A native of Ireland. Age 61 or over. Occupation, laborer.

When investigated it was found that this dependent was living with his sister, who was willing and able to keep him.

CASE 85. A native of England. Age 50.

It was found that he was not an American citizen, and that he lived in an expensively furnished apartment. He had a son in the office of the New York Taxicab Co., earning $15 a week, and a daughter, who earned $15 a week as a bookkeeper. The dependent's wife earned $10 a week by sewing. He was crippled and partially paralyzed. As soon as the family heard that the dependent was in this Home the son took him out.

CASE 86. A native of Russia. Age 33. Occupation, carpenter.

A friend was seen who said that the family, consisting of husband, wife, and 3 children, had lived at the address given. The husband became sick and went to a municipal hospital for treatment. He claimed that he left because he got no care. This friend could not tell the nature of his sickness but said that he and his wife were both sick at the time of the interview, 6 months after his discharge from the Home. The Home records showed this dependent to have been an alien. His parents were in Russia.

CASE 87. A native of Germany. Age 66. Occupation, janitor or ironworker.

The Home records showed that this dependent was an unnaturalized alien. The investigators found that the dependent's friends were unknown at the address given.

CASE 88. A native of Italy. Age 48. Occupation, laborer.

This case was referred to the State Board of Charities, and the dependent and his family of 4 were removed to New Britain, Conn. The Home records showed a residence of only 3 weeks in the United States.

CASE 89. A native of Germany. Age 61 or over. Occupation, butcher.

A friend of this dependent said that he was a veteran and received a pension. The Colony records showed that he was in good condition and able to work.

CASE 90. A native of Russia. Age 27. Occupation, ironer.

The Home records showed that this dependent was an unnaturalized alien. They also showed that he was in good physical condition and able to work. It was learned at the State Board of Charities that he had been sent back to Russia.

CASE 91. A native of Germany. Age 58 or over. Occupation, bookbinder.

The Home records showed that this dependent was an unnaturalized alien. They also showed that he was in fair physical condition and could do light work.

CASE 92. A native of Russia. Age 24. Occupation, cabinet-maker.

The Home records showed that this dependent had been only 15 months in the United States. They showed him to be in good condition and able to work. When investigated it was found that he had been sent back to Russia by the State Board of Charities.

CASE 93. A native of the United States. Age 18. A school-boy.

This inmate had been in a hospital in Philadelphia and was to have been sent to an almshouse there. The father of the patient, on hearing of the proposed removal, brought the boy to New York and had him admitted to the City Home. The boy was told to state on admission that his residence was in New York. Investigation developed that the father was also a non-resident, and that the State Board of Charities had the case and the dependent was to be returned to Philadelphia by them. The boy claimed a 5 months residence in the State, according to the entry made at the Home at the time of his admission.

CASE 94. A native of Ireland. Age 51 or over. Occupation, stableman.

The Colony records showed that this dependent was an unnaturalized alien. They also showed him to be able to work but that he was out of employment at the time of admission. He had no relatives in this country.

CASE 95. A native of Belgium. Age 69. Occupation, laundryman.

The Home records showed that this dependent was an unnaturalized alien. The records showed him to be in good condition and able to work. When investigated it was found that the addresses given were old, and that the dependent had not been seen for several years.

CASE 96. A native of Ireland. Age 74. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. Investigation proved that a false address had been given for his friend. No residence was given for himself.

CASE 97. A native of Ireland. Age 68. Occupation, laborer.

The Home records showed this dependent to be a non-resident, only 4 days in the city, in good physical condition and able to work. He had a brother living in New Jersey.

CASE 98. A native of Russia. Age 74. Occupation, baker.

A widower, with 2 sons and 2 married daughters. One of his daughters said that he was an alien. This fact also appeared on the City Home record.

CASE 99. A native of Scotland. Age 66. Occupation, stonecutter.

The Home records showed that this dependent was an unnaturalized alien. The investigators found that the dependent and his wife were both unknown at the addresses given.

CASE 100. A native of the United States. Age 31. Occupation, housewife.

At the time of investigation an aunt said that the dependent owned property with equity worth $2,500. She had heard that the dependent was at another public institution, where her husband was paying for her.

CASE 101. A native of Ireland. Age 26. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. They also showed that he was physically able to work but that he had been out of employment at the time of admission.

CASE 102. A native of the United States. Age 54. Occupation, harness-maker.

The Home records showed that the dependent was a non-resident who had been in the State only 4 days. They also showed that he was in good condition and able to work. When investigated it was found that he had been sent to Connecticut by the State Board of Charities.

CASE 103. A native of Ireland. Age 66 or over. Occupation, cook.

The Colony records showed that this dependent was well and able to work but that he was out of employment at the time of admission. He left the Colony to engage in work.

CASE 104. A native of the United States. Age 67. Occupation, carpenter.

The dependent had a wife and daughter living but had been out of touch with them for a long time. A friend was interviewed who said that the wife and daughter were in good circumstances but had left him dependent upon a cousin for years.

CASE 105. A native of Holland. Age 53. Occupation, farmhand.

The Colony records showed that this dependent was an unnaturalized alien. He was transferred to the payroll at the Colony, although he received small sums of money from Holland.

CASE 106. A native of Ireland. Age 60. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. There were 3 entries of admissions of this dependent.

CASE 107. A native of England. Age 66. Occupation, actor.

The Home records showed that the dependent had been in the United States only 2 months and that he was in good condition. It was found that the State Board of Charities had sent him back to England.

CASE 108. A native of Ireland. Age 37. Occupation, waiter.

The Home records showed that this dependent was an unnaturalized alien.

CASE 109. A native of Ireland. Age 58. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. Neither the dependent nor his friends were known at the addresses given for them on the Home records.

CASE 110. A native of Germany. Age 59 or over. Occupation, baker.

Unmarried. The entry on the Home records showed that the dependent was not a citizen and had been admitted to the Home 6 times.

CASE 111. A native of Ireland. Age 45. Occupation, waiter.

The Home records showed that this dependent was an unnaturalized alien. A friend said that the dependent was destitute and without relatives in the United States.

CASE 112. A native of Ireland. Age 59. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. He was a widower. A friend said that he was lame but able to work.

CASE 113. A native of the United States. Age 22. Occupation, laborer.

The Home records showed that this dependent was a non-resident who had been in the State only 3 months. They also showed him to be in good physical condition and able to work.

CASE 114. A native of Ireland. Age 21. Occupation, laborer.

Unmarried. This dependent was reported to the State Board of Charities and was to have been deported by them. Upon the dependent's sister interceding with the State Board of Charities he was discharged in her custody, with the understanding that if he returned to the institution again he would be deported. The dependent's history at the Home showed that he was an alien, only 14 months in the United States, and that he was admitted twice to this Home; that he entered the first time as a case for investigation by the State Board of Charities, and was discharged the second time by order of the Superintendent of the Department of State and Alien Poor of the Board.

CASE 115. A native of Ireland. Age 64 or over. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. When investigated it was found that the dependent and his friends were all unknown at the addresses given.

CASE 116. A native of Ireland. Age 67. Occupation, moulder.

The investigators found this dependent to be an unnaturalized alien. They also found that he had relatives ready to support him but that he would not remain with them. A relative considered him feeble-minded.

CASE 117. A native of the United States. Age 44. Occupation, driver.

He lived for some time with his brother. The latter's wife said that she and her husband have a home for the dependent as long as he behaves himself. He had another brother in New York who was in good circumstances and would keep him if he did not make himself a nuisance. The sister-in-law said that she had not seen the dependent since the previous May, when she saw him in the Brooklyn Home. Her daughter was carrying a burial insurance for him. This family and the brother in New York might be willing to pay for his care.

CASE 118. A native of Ireland. Age 54. Occupation, horseshoer.

His wife and children lived in Brooklyn. The wife was not found at home, as she goes out working daily. The children were in school. The housekeeper was seen, and said that the man was a blacksmith, and could work and support his family. The wife was obliged to take care of her children, and thought that her husband should be compelled to do something for her.

CASE 119. A native of Ireland. Age 21. Occupation, engineer.

The Colony records showed that this dependent was an unnaturalized alien.

CASE 120. A native of Ireland. Age 25. Occupation, fireman.

The Colony records showed that this dependent was an alien who had been in the United States only 4 years, and in New York State only 3 days. The records also showed that he was able to work.

CASE 121. A native of Russia. Age 28. Occupation, mattress-maker.

The Home records showed that this dependent was an unnaturalized alien. He was unmarried. This case was referred to the State Board of Charities and closed by them without any action having been taken.

CASE 122. A native of Ireland.

This dependent had been in the United States 50 years and is a citizen. He had been ill for 3 years and unable to work. His wife stated that he was a veteran and in receipt of a pension.

CASE 123. A native of France. Age 78. Occupation, engineer.

The Home records showed that this dependent was an unnaturalized alien. According to the stepdaughter the 2 sons had been paying their father $10 per month for several years.

CASE 124. A native of Russia. Age 19. Occupation, kitchenman.

This case was referred to the State Board of Charities and closed by them without any action having been taken. The dependent's history at the Home showed that he was a homeless and friendless alien, of only 6 months residence in New York City.

CASE 125. A native of Russia. Age 46. Occupation, painter.

The Home records showed that this dependent was an unnaturalized alien. His brother-in-law said that he was in good physical condition but entered the Home on account of a broken arm. He returned, at private expense, to Russia, where his wife and children live.

CASE 126. A native of the United States. Age 22. Occupation, laborer.

This dependent was a non-resident who had been in the State only 3 months, according to the Home records. They also showed him to be in good condition and able to work.

CASE 127. A native of Russia. Age 45. Occupation, laborer.

This case could not be investigated, as the address given was a lodging-house. The history record of this dependent showed that he was not a citizen.

CASE 128. A native of Ireland. Age 66. Occupation, cooper.

The Home records showed that this dependent was an unnaturalized alien.

CASE 129. A native of Germany. Age 49. Occupation, peddler.

The dependent's wife was interviewed. She stated that he had been crippled 10 years, and left home to go to a hospital for treatment. She learned that he had been transferred and went to bring him home. About the same time the dependent's daughter learned where he was, and she took him out. She was supporting him at the time of the investigation. The wife was willing to support him if he wished to return to her. He appeared on the record of the Home as an alien.

CASE 130. A native of Russia. Age 42. Occupation, paper-box maker.

The Home records showed that this dependent was an unnaturalized alien. He was crippled from locomotor ataxia. He had 8 children, 2 of whom were working at $6 a week.

CASE 131. A native of Ireland. Age 62. Occupation, kitchenman.

The Colony records showed that this dependent was an unnaturalized alien. He was without relatives or friends in the United States.

CASE 132. A native of Germany. Age 59 or over. Occupation, furrier.

The Colony records showed that this dependent was an unnaturalized alien. He was admitted 7 times to the Home, and, when investigated, it was found that the dependent was unknown at the address given.

CASE 133. A native of Ireland. Age 57. Occupation, packer.

The Home records showed that this dependent was an unnaturalized alien. The dependent was found to be living upon the bounty of his son. His wife also was working by the day.

CASE 134. A native of Wales. Age 52. Occupation, janitor.

The dependent's wife was able to keep him in a private hospital as a paying patient for 9 months, and, when she found he did not like the Home, took care of him at home until he died.

CASE 135. A native of Holland. Age 44 or over. Occupation, butcher.

The Home records showed that this dependent was an unnaturalized alien and was admitted to the Home 9 times. He was unmarried and had no relatives in the United States. He received small sums of money from Holland.

CASE 136. A native of Ireland. Age 45. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. They also showed him to be a cripple.

CASE 137. A native of Germany. Age 60. Occupation, houseman.

This case had been referred to the State Board of Charities and the dependent had been deported by them to Sweden. He had afterward returned to the United States and was detained in Philadelphia.

CASE 138. A native of Ireland. Age 68. Occupation, laborer.

The dependent was living with his son, who was supporting him. He said he had left the Home because he was required to work and could not do so because of rheumatism, and that for the same reason he was unable to work now. The record at the Home showed 2 admissions of this dependent.

CASE 139. A native of England. Age 46. Occupation, laborer.

The Colony records showed that this dependent was an unnaturalized alien. He was without relatives or friends in the United States.

CASE 140. A native of the United States. Age 64. Occupation, laborer.

The Colony records showed that this dependent was able to work but that he was out of employment at the time of admission. When investigated it was found that the dependent was working. His wife said that they had property and intended to trade it for an apartment costing $6,700.

CASE 141. A native of the United States. Age 45. Occupation, boilerman.

The Home records showed that this dependent was a non-resident, having been in the State only 4 weeks. He was a cripple. It was found that the State Board of Charities had sent him to Illinois.

CASE 142. A native of Russia. Age 24. Occupation, waiter.

An unnaturalized alien, who had been in New York State only 2 months, according to the Colony records. It was also shown that he was able to work but was out of employment at the time of admission.

CASE 143. A native of England. Age 58. Occupation, waiter.

A sister said that this dependent made good wages when he worked but that he was a heavy drinker. She said the dependent was at work at the time of investigation.

CASE 144. A native of the United States. Age 28. Occupation, furnace-setter.

This dependent was a non-resident, having been in the State only 2 days, according to the Home records. They showed him to be in good condition and able to work. Investigation found that he had been sent to his wife in Kentucky by the State Board of Charities.

CASE 145. A native of Italy. Age 30. Occupation, hair-worker.

This case was referred to the State Board of Charities and closed by them without any action having been taken. The Home records showed this dependent to have been an alien.

CASE 146. A native of Italy. Age 68. Occupation, peddler.

The Colony records showed that this dependent was an unnaturalized alien. At the time of investigation it was found that the dependent was unknown at the address given.

CASE 147. A native of the United States. Age 56. Occupation, laborer.

A friend said that this dependent had a father in New Jersey who was well-to-do. The dependent was a cripple.

CASE 148. A native of Germany. Age 40. Occupation, baker.

The Colony records showed that this dependent was an unnaturalized alien. The investigators found that both the dependent and a friend were unknown at the addresses given.

CASE 149. A native of Italy. Age 62. Occupation, fruit peddler.

The husband of the dependent's stepdaughter was interviewed. He and his wife said that they were willing to support the dependent. The former appeared to be doing a good business as a shoemaker and able to maintain the dependent.

CASE 150. A native of the United States. Age 52. Occupation, driver.

A sister-in-law said that the dependent lived with them in Brooklyn when he was behaving himself. She said that he had a brother in New York in good circumstances. A nephew said that the dependent was a "big, husky fellow," and able to work. He was unmarried.

CASE 151. A native of Russia. Age 45. Occupation, peddler.

The Home records showed that this dependent was an unnaturalized alien. They also showed him to be a cripple and unable to work. The investigators were unable to locate either the dependent or his friend at the addresses given.

CASE 152. A native of Italy. Age 30. Occupation, hair-worker.

The Home records showed that this dependent was an unnaturalized alien. This was confirmed by an interview with him. He was found working for his brother. His wife was also earning enough for the support of herself and the children. The records showed 2 admissions of this dependent.

CASE 153. A native of Ireland. Age 63. Occupation, shoemaker.

The Home records showed that this dependent was an unnaturalized alien. A friend who said he had seen the dependent about a month after his discharge said that he seemed to be in good health and able to work to earn his own support. The records showed 2 admissions of this dependent. He was unmarried.

CASE 154. A native of Germany. Age 72. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. They also showed him to be in good condition and able to work. The dependent's friend was unknown at the address given.

CASE 155. A native of Germany. Age 70.

The dependent lived with his son. The latter said that the dependent left his house of his own accord and went to the Home. He also said that he could not pay for the dependent's maintenance there, but that if he was willing to take his place in his home, and not annoy the children when they wanted to play, he could come back.

CASE 156. A native of Germany. Age 65. Occupation, cigar-maker.

The Home records showed that this dependent was an unnaturalized alien who had been in the United States only 6 weeks. They also showed him to be in good condition and able to work. It was learned that the State Board of Charities had sent the dependent to Canada.

CASE 157. A native of Austria. Age 26. Occupation, waiter.

The Home records showed that this dependent was an alien who had been in the United States only 9 months. It was also shown that he was in good condition and able to work. When investigated it was learned that he had been sent back to Austria by the State Board of Charities.

CASE 158. A native of Ireland.

The dependent had been in this country 60 years and was a citizen. His daughter said her husband had a music store. Her father had visited her for a short time, and she had not known that he was in the Home. No inquiry about her father had ever been made by the Department of Charities. She thought that the dependent was working in New York, and did not think that she should support him. She gave the name of another daughter living in New York City. Inquiry was made at this daughter's address, where the janitor said that the family had moved and that the son-in-law had held a city position paying $3,600. The *City Record* showed this man to be a clerk, receiving a salary of $2,850, increased from $2,700 within a year.

CASE 159. A native of Ireland. Age 72.

His widow said that he had become quite feeble, and that in going for his daily walk one day he disappeared. After 3 days she located him at Kings County Hospital. He seemed pretty well at the time, but, upon advice of the doctor, she left him there. She went back a week later and found him in the almshouse hospital, sick in bed. He had just received extreme unction. She brought him home in an ambulance, July 18, and he died July 24, 1912. The widow said she received no word from the Bureau of Dependent Adults or from the Home that he had been sent either to the Hospital or the Home, and she only learned of his whereabouts by going to the Deputy Commissioner's office and getting some one to run over the permit stubs until he found the address of the dependent's home entered on one of them. The family would never have allowed him to become a City charge had they been able to prevent it.

CASE 160. A native of Italy. Age 69. Occupation, barber.

The Home records showed that this dependent was an unnaturalized alien. They also showed him to be in good condition and able to work. When investigated it was found that the dependent had asked to be discharged because he did not like the Home, and that he was then making about $20 per week in a barber shop, with no one dependent upon him.

CASE 161. A native of the United States. Age 34. Occupation, orderly.

The residence given was a lodging-house and saloon, and the inmate could not be located. However, his brother, a former assemblyman, now on the editorial staff

of a newspaper, was seen in his office. He said that his brother was a single man, whose father and mother were dead. Some years before he had had an accident, breaking his kneecap. He went to pieces after that and had been a disgrace to the family. The brother had offered repeatedly to place him in a good political position if he would straighten up. The brother also said he would do anything he could for his maintenance that was proper to do, and that there was no reason why he should have applied for relief in Brooklyn.

CASE 162. A native of Russia. Age 31. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. It was also shown that he had rheumatism and could not work. When investigated it was learned that he had been sent back to Russia by the State Board of Charities.

CASE 163. A native of Italy. Age 72. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. He was unmarried. A niece of the dependent was interviewed and she claimed that he was destitute. He was still in the Home after a stay of 6 months.

CASE 164. A native of England. Age 76.

He claimed to have been naturalized. His niece was seen and said that the dependent had a son, a mechanic, earning about $18 per week when at work. The question of support of the dependent was taken into court and the judge told the son that he must pay $3 a week to the father. This amount would cover the weekly expense for the dependent in the Home, according to the estimated expense per dependent, published in the annual reports of the Department of Public Charities.

CASE 165. A native of Germany. Age 50 or over. Occupation, blacksmith.

The Home records showed that this dependent was an unnaturalized alien. At the time of investigation no residence was found at the address given for the dependent.

CASE 166. A native of Ireland. Age 53.

His wife, at the residence address given, said that he had left her in May, on the date of his admission to the Home, saying that he was going to a hospital. She had telephoned to Kings County Hospital and got word that he was not there. She said that he was an able-bodied man and should support his family. When told by the investigator that he was in the Home she said that she would get him out, as there was no reason for him to be a dependent.

CASE 167.

A neighbor stated that the dependent was a soldier's widow and received a pension of $36 every 3 months. Her niece had all the papers relating to the pension.

CASE 168. A native of Ireland.

At the son's address no response was made to knocks at the apartment door, although 3 visits were made. A neighbor said the people were at home and would not open the door, and also reported that the 2 sons and a sister were all employed.

CASE 169. A native of Ireland. Age 72.

He had been in the United States 35 years but his citizenship was not known to the person interviewed. His niece's husband said that the dependent was not able to work, and that he and his wife were willing to keep him if he would return to them. The man interviewed made a fair living and had no one but his wife dependent upon him.

CASE 170. A native of England. Age 30. Occupation, draughtsman.

The Home records showed that this dependent was a non-resident who had been in the State only 3 weeks. They also showed that he was in a good condition and able to work. When investigated it was found that the State Board of Charities had sent him to Illinois.

CASE 171. A native of Ireland. Age 70.

The dependent was seen at the home of her daughter and said that she had lived there, but had felt she ought to go to the Home instead of being a burden upon her daughter. The rooms were well furnished and well kept. The daughter said that she always had a home for her mother.

CASE 172. A native of Norway. Age 36.

The dependent had been in the country 5 years but had never filed citizenship papers. The dependent, and also a friend, who was acquainted with the illness which led to the dependent's admission to the Home, were seen. These 2 men had been working in North Carolina. Both had become sick with malaria, and the dependent returned here and went to Kings County Hospital. Since then he had had no treatment, and, on the 24th of September, after refusing to be transferred to the Colony, he was discharged from the Home. He said his eyes were failing and that his hearing was becoming defective. The Department of State and Alien Poor of the State Board of Charities had no record of any application having been made for the investigation of this alien for possible deportation.

CASE 173. A native of Germany. Age 80.

A Jewish woman, living in Brooklyn. Her son was seen in Manhattan, where he had a prosperous liquor business. He said that he had twice made arrangements to put his mother in a Jewish Home for the Aged but his sister was unwilling to have him take her there. A week or so later he had had a summons from the Domestic Relations Court, where he had made a settlement for the payment of $8 per month for his mother. This he sent on the first of each month regularly. If he knew that his mother would go into a Jewish Home when the arrangements were made he would make another effort for her and pay the expense of her maintenance there.

CASE 174. A native of England. Age 70. Occupation, painter.

A friend of this dependent said that he had returned to England several times, and the last time remained there about 1½ years. She did not know whether he was a citizen or not. The information gathered seemed to indicate that this dependent had probably become expatriated.

CASE 175. A native of Ireland. Age 72.

At an employment agency it was learned that 1 of the daughters was well able to provide for the dependent, and was willing to do so. The dependent's son earned about $15 a week as a cook, and was also willing to provide for his mother. The daughter owned a restaurant. Another daughter said that these 2 children intended to remove the mother from the Home as soon as they could find a place for her. Corroboration of the statement that they were willing to provide for her was obtained.

CASE 176. A native of Ireland. Age 46.

Her former employer said that the dependent had worked for her and earned $10 a month. The employer carried burial insurance for her. She hurt her foot and went to Kings County Hospital, and after her foot was well she was transferred to the Home. Her employer said that there were no known relatives to care for the dependent but that she would be very glad to have her back, as she was a good worker. The employer said she thought that the dependent would rather leave the Home and work than be dependent on charity. When the dependent was seen later at the Home and was told of the opening she was glad to accept it, and was discharged the next day to take the position.

CASE 177. A native of Ireland. Age 75 years. Occupation, laborer.

A naturalized citizen who had served in the U. S. navy and was receiving a pension from the U. S. Government. His daughter-in-law stated that he had 4 sons and 2 daughters but that they refused to care for their father. The dependent had been unable to work for some time before going to the Home and had been a hospital patient.

CASE 178. A native of the United States. Age 75. Occupation, laborer.

His daughter said that his son was a first-rate fireman, making $1,400 per year, and that he allowed the dependent $3 per week. This could have paid the dependent's expenses at the Home, according to the estimate for maintenance published in the annual reports of the Department of Public Charities.

CASE 179. A native of Ireland. Age 60.

The family could not be located, but a woman with whom they formerly had rooms was seen. She said there was a daughter, who was a good girl and worked and earned fair wages, and a son who was steady. They paid the expenses of their father and mother when with them, and she understood that they were now keeping up a home for them since the dependent's discharge from the Home.

CASE 180. A native of Ireland. Age 75.

It was learned that she owned a one-third interest in the property at the address given as her residence, and also owned lots in Long Island City. An intimate friend said that the stepdaughters with whom the dependent lived sent her to the Home, as they worked and she was feeble and could not be left alone. The stepdaughters were seen and said that they were willing to pay the dependent's expenses out of the estate.

CASE 181. A native of Germany. Age 68. Occupation, laborer.

It was said that 1 daughter and her husband owned the house in which they lived, and were well able to care for their father. He had left the Home because his children had promised to pay for a room for him.

CASE 182. A native of Scotland. Age 63. Occupation, clerk.

This dependent was an alien who had been in the United States only 4 years. The investigators found that the dependent was unknown at the addresses given.

CASE 183. A native of Germany. Age 74. Occupation, farm laborer.

The janitress at the dependent's residence said that his son had removed to his own house at Coney Island. She said dependent also had a son in Germany. The dependent's son was seen and was found to own his house.

CASE 184. A native of the United States. Age 26. No occupation.

The dependent was deaf, dumb, and half blind. He wrote in answer to written questions that he was a native of New Jersey, residing before admission in that state, and that his brother brought him to New York and had had him admitted to the Home. The entry on the Home record was that this dependent had lived 25 years in the city, but his brother's address, at both the Home and the Bureau of Dependent Adults, was given in New Jersey.

CASE 185. A native of Ireland. Age 67. Occupation, moulder.

The investigators found this dependent to be an alien who had not been naturalized. They also found that he had relatives ready to support him, but he would not remain with them. A relative considered him feeble-minded.

CASE 186. A native of Russia. Age 20. Occupation, dishwasher.

This case was referred to the State Board of Charities and the dependent was returned to Russia by the Board. His history at the Home showed that he had been in the United States only 6 months.

CASE 187. A native of Norway. Age 70. Occupation, sailor.

The Home records showed that this dependent was an unnaturalized alien. They gave no definite address of the residence and no friends.

CASE 188. A native of the United States. Age 63. Occupation, laborer.

The landlady of the dependent said that the dependent was a veteran, without family. He was admitted to the Home 7 times.

CASE 189. A native of England. Age 58 or over. Occupation, ironworker.

The Home records showed that this dependent was an unnaturalized alien. None of the 3 addresses given as the residences of the dependent and his friends were residential.

CASE 190. A native of the United States. Age 76. Occupation, engineer.

A friend stated that she was willing to give the dependent a home if he would watch the house while they were out. He had been seen looking for employment. The Home records showed 5 admissions there of this dependent.

CASE 191. A native of Ireland. Age 76. Occupation, blacksmith.

A widower. This dependent's daughter refused to give any information, except that it was entirely unnecessary for her father to be in the Home. She asked that he be refused admission the next time he applied for it. The Home records showed 4 admissions of this dependent.

CASE 192. A native of the United States. Age 62.

At the home of her son she said that her son did not live with his wife, and that she kept house for him and her grandson. She was taken to Kings County Hospital when she had had a paralytic stroke which had crippled her. As soon as she was better she was told that they needed the bed and was sent to the Home. Her son took her out at her request and was supporting her.

CASE 193. A native of Sweden. Age 62.

The occupants of the house given as her residence said that they knew little about her, except that she had boarded with the former occupants, whose present whereabouts were not known, and that she was able to work to earn her own support.

CASE 194. A native of the United States. Age 68. Occupation, storekeeper.

This dependent was brought to a hospital by ambulance from the Pennsylvania R. R. Station, having just returned from a stay of a year and a half in Toronto, Canada. While in the hospital $1.50 per day was paid for the patient by his son. The patient was transferred to this Home, from which place the case was referred to the State Board of Charities for investigation for possible removal. Before the State Board took action on the case they were notified that the patient had been admitted to the Home through some mistake, and that relatives were able and willing to care for the patient in their own home. The patient was, therefore, discharged by order of the State Board to these relatives. The home of these relatives gave every indication that they were prosperous.

CASE 195. A native of Austria. Age 53. Occupation, presser.

The dependent has a son in Detroit, Mich., who is a printer by trade. The Home records have no information regarding this dependent's citizenship, but his wife said that he was not a citizen.

CASE 196. A native of Russia. Age 31. Occupation, painter.

The dependent was sent to California by the State Board of Charities, as he was not only an alien, but also a non-resident of New York City. His wife and children had been in California.

CASE 197. A native of Italy, where her husband still resided.

The dependent had 2 sons and a daughter in the city. One son has a small grocery store and the other is a plasterer by trade. Both professed to have only meager incomes. This dependent was not a citizen, although the Home records had no information on this point, and had been in the United States only 4 or 5 years.

CASE 198. A native of England. Age 68.

He said he had been in the Home 3 months, and left because he was asked to go to the Colony, as he did not want to go where his relatives and friends could never visit him. He said that he had had his sons in court to make them pay for his support but that only 1 of the sons had paid his share. The dependent made 25 cents a day and lived with a friend. He had 2 sons who were employed in the Street Cleaning Department, and another son who was an officer for a private philanthropic organization.

CASE 199. A native of Ireland. Age 61.

She had 2 daughters living in Brooklyn. The daughter interviewed said that she has always kept her mother with her, and was willing to give her a home. She said that her sister worked and earned $7 or $8 a week in a cigar factory. Her husband was quite willing to maintain his mother-in-law. This daughter said that there was another daughter in New Jersey who was in good circumstances and could help.

CASE 200. A native of England. Age 50.

The daughter said that she was willing to give her mother a home. The daughter's husband was a cook, and when he worked in hotels his salary was about $100 a month. In restaurants it was about $18 a week. The mother was not able to do much work. She earned about $12 to $16 a month as a cleaner in hotels.

CASE 201. A native of Italy and unnaturalized. Age 73.

His son, who had a good barber shop, employing 3 barbers, was interviewed. He said that his father was stricken on the street. A policeman found him there and sent him to Kings County Hospital. This was on Monday, and on the following

Friday they received word from Kings County Hospital that he was there. The son located him at the Brooklyn Home and immediately brought him to his own home, where he died a week later. The son had not been asked to pay anything for his father's maintenance.

CASE 202. A native of Germany. Age 66. Occupation, cigar-maker.

The dependent lived for a long time in Brewster, N. Y. His sight failed and he came to New York to live with his sister, and was with her only 4 or 5 months. Being too old to support anyone but herself, she was obliged to allow him to become a dependent. He was admitted to the Brooklyn Home and was discharged because of his refusal to go to Farm Colony. He then returned to Brewster, N. Y., to apply for admission to the county almshouse there. His sister said that he had never had a residence in New York City.

CASE 203. A native of Germany. Age 79.

Her granddaughter was interviewed and said that the dependent went to the Home because no one wanted to keep her. She had been living with her daughter at this address, but, as the husband had been out of work, they were in straits. The dependent was in the Brooklyn Home, and was continually worrying for fear she would be sent to Farm Colony. She said all the old women lived in fear of the day when it would be their turn to go there. When she was ordered to go she would refuse and would then be taken by another daughter who was able to care for her. The families of both of these daughters were in ordinary circumstances but able to care for the dependent in their own homes.

CASE 204. A native of Germany. Age 75. Occupation, clerk.

He had had considerable means and had been an architect in the employ of one of the City departments. He was unfortunate in losing his money and his son, the only child, was unwilling to do anything for him. The son was a bookkeeper, earning $15 a week, and supported the mother, who lived with him, paying $12 a month rent. The old man was living on money that was being sent to him by a sister in Germany. Inquiry at his address was made. It was said there that he went out to work in an architect's office each day and returned home every evening about 8 o'clock.

CASE 205. A native of the United States. Age 67.

An old lady, whose son was paying to the Domestic Relations Court $1 a week for her support. This money was turned over to her when she called for it. The dependent was discharged from the Home. There was $3 waiting for her at the Domestic Relations Court at the time of the investigator's visit.

CASE 206. A native of Italy. Age 64. Occupation, laborer.

This case was referred to the State Board of Charities and the dependent was returned by them to Italy. The Home record showed that he was homeless and friendless.

CASE 207. A native of Germany. Age 38. Occupation, bartender.

The dependent was an alien, and had been an inmate of an insane asylum. His sister-in-law said his wife's family would help him if he would only keep sober and work.

CASE 208. A native of Ireland. Age 71 years. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien. He has never been located at the address given on the Home records. He was known to have been on the tuberculosis records of the Department of Health, and has been reported to them as being in the hospital several times. The Home records showed that the dependent has been admitted to the Home 18 or 19 times, his first admission having been in 1903.

CASE 209. A native of Russia. Age 90. Occupation, peddler.

The Home records showed that this dependent was an unnaturalized alien.

CASE 210. A native of Germany. Age 75. Occupation, ticket agent.

At the son's address it was found that the latter and his wife had no children and had occupied a 6-room apartment, at $38 per month rent.

CASE 211. A native of Ireland. Age 54. Occupation, laborer.

A United States citizen who had been admitted to the Home 8 times. The dependent was seen working at the Home. He stated that he was in very good health, and expected to go out soon and go to work as longshoreman or at hod-carrying. He looked strong. He was unknown at the address given as his residence.

CASE 212. A native of Germany. Age 65. Occupation, laborer.

His wife said that her husband was able to work to earn his support. She was about to take a place as janitress. She claimed her husband had left the Home because he was unwilling to be transferred to Farm Colony.

CASE 213. A native of Germany. Age 71. Occupation, laborer.

The Home records showed that this dependent was an unnaturalized alien.

CASE 214. A native of Ireland. Age 76. Occupation, laborer.

This dependent was brought to a municipal institution directly from a transatlantic steamship, with $260 on his person. This case was referred to the State Board of Charities and closed by them without any action having been taken. He had been only 3 days in the State at the time of his admission to the Home, according to the entry made then.

CASE 215. A native of Bohemia. Age 24. Occupation, clerk.

The Home records showed that he was an alien who had been in the country only 18 months, and that he was in good physical condition. Investigation developed the fact that his parents and immediate family were all in Bohemia.

CASE 216. A native of Germany. Age 76. Occupation, kitchenman.

The Home records showed that this dependent was an unnaturalized alien. He was unmarried, with no relatives in the United States. The investigator was unable to locate him at the address given.

CASE 217. A native of Germany. Age 28. Occupation, plumber.

The dependent's former employer was given as his friend on the Home records. He stated that dependent was a good worker and able-bodied before entering the army. He was then paralyzed on both sides. The dependent was seen at the Home, and stated that he had been discharged for disability, acquired while serving as a soldier. His father had 7 children under 14 years of age and was unable to support him. The dependent had been admitted 6 times to this institution, according to the records.

CASE 218. A native of Germany. Age 61 or over. Occupation, driver or butcher.

A friend of the dependent said that he was a veteran and received a pension. The Home records showed he was in good physical condition and able to work.

CASE 219. A native of Ireland. Age 57 or over. Occupation, builder.

The Home records showed that this dependent was an unnaturalized alien. He and his daughter were not known at the address given as their residence.

CASE 220. A native of Germany. Age 66. Occupation, farmer.

The Home records showed that this dependent was an unnaturalized alien. A friend in charge of an employment agency said that he had often secured positions for the dependent, but he had never saved anything, being a heavy drinker. He was unmarried.

CASE 221. A native of Austria. Age 54. Occupation, laborer.

A friend stated that the dependent walked on crutches and was unable to work. Up to 14 or 15 months before he had received a small amount of money quarterly from Austria for 8 or 9 years; before that the amount had been larger. This friend did not know who sent it to him. The dependent's father, who died about 11 years ago, had had a considerable amount of money. The dependent had a daughter in comfortable circumstances. She was the wife of an officer in the Austrian army. The dependent hesitated to return to Austria because of the shock the contrast between his condition and the daughter's would cause her. The Home records showed 15 admissions of this dependent.

CASE 222. A native of Canada. Age 64 or over. Occupation, cook.

A brother said that the dependent was a heavy drinker and for this reason could not keep a job. He has a sister living in Canada who is prosperous. The brother does not know whether dependent is a naturalized citizen or not, and no entry of information on this point was made on the Home records.

CASE 223. A native of the United States. Age 42. Occupation, civil engineer.

His brother said that the dependent was transferred from the Home to another public institution, where his expenses had been paid, and was to be transferred from there to a private institution. The dependent was on the State payroll and had independent means. The brother interviewed was living in an elevator apartment and apparently in very comfortable circumstances.

CASE 224. A native of Hungary. Age 68. Occupation, carpenter.

This dependent and his wife were seen at his home address. He stated that he owned no property of any kind, and was unable to pay. He has been in America a good many years but had not become a citizen. The information at the Home was to the effect that he was an alien.

Section III.—SOME HOSPITAL PROBLEMS

1. Clinical Records in Bellevue Hospital
2. Autopsy Findings in Bellevue Hospital Compared with Clinical Diagnoses
3. Distribution of Ward Space in Bellevue Hospital
4. Transfer of Patients to and from Bellevue Hospital and to and from Kings County Hospital
5. The Morgue Service.

I. CLINICAL RECORDS IN BELLEVUE HOSPITAL

THE INVESTIGATION

BY

DR. L. L. WILLIAMS

One hundred and thirty-five clinical records taken from the files without selection, except as to type of disease, were examined as to their sufficiency. An equal number was taken from each division, and a few from services not connected with divisions. Nearly all of these records are histories of disease of a serious type. It has been noted in examining case records for other purposes that cases of serious disease are, as a rule, better written up; consequently, in taking the present series for examination and criticism any error which may have been made is in favor of the Hospital. For purposes of discussion, the records examined may be divided into three classes: good, incomplete, and poor.

The case histories classed as good contained good admission notes, including a careful record of the physical examination; full laboratory notes when required; clinical notes at reasonably short intervals; nurse's daily notes and charts; and histories which gave a connected account of the course of the disease and sufficient indication of the patient's condition at the termination of treatment.

Incomplete records include, for the most part, those in which the record of examination upon admission was well written but which thereafter consisted only of nurse's notes and the usual chart of temperature, etc., bedside notes recorded by the interne being conspicuous by their absence. A few of these incomplete records contained a discharge note, giving the patient's condition at discharge. A statement of the patient's condition at the date of discharge was very frequently omitted. The formal result noted in the captions, "cured," "improved," "unimproved," or "died," is scarcely a sufficient statement of the outcome (except in the case of death), especially when the result noted is "improved." When such a notation is made it is obviously necessary that the condition at discharge be accurately described if the clinical record is to be of any value in ascertaining the results of treatment. Another common practice is, when a patient has been admitted more than once for the same ailment, to refer to the previous record for an account of his condition but without giving the date of previous treatment. Such a record cannot be regarded as complete.

The records classed as poor were those in which the defects were so serious that no adequate notion of what had actually happened to the patient could be gathered from their perusal. Some defects noted were: failure to note in the initial record of examination important conditions referred to in the body of the report; absence of clinical notes by the house officer, other than the notes on admission, in important cases remaining in the Hospital for considerable periods; absence of clinical notes after important operations, the subsequent course being a matter of conjecture and the question of aseptic healing or septic infection to be inferred from the nurse's notes of "dressings changed," etc.; failure of the record to justify the diagnosis given in the caption; absence of any record of important

complications noted in caption. One record consisted of nothing except the coroner's statement of the anatomical diagnosis.

Of the 135 clinical records examined, 77, or 57 per cent., were regarded as good case histories. Some of these were very well written; others, while showing minor defects, were, nevertheless, adequate descriptions. All of the records in this class may be regarded as creditable to the institution.

Forty-one clinical records, or 30 per cent., were incomplete, and 17, or 13 per cent., were regarded as poor, these two classes showing defects of the types described on the preceding page.

It is of interest to observe that there was a considerable difference in the excellence of the clinical histories in the several divisions of the Hospital, in some divisions the percentage of good case histories being much higher than in others. In Division (X), for example, there were found: good histories, 79 per cent.; incomplete histories, 18 per cent.; poor histories, 3 per cent. In Division (Y) there were: good histories, 36.5 per cent.; incomplete histories, 36.5 per cent.; poor histories, 27 per cent.

Such a disparity indicates either that the internes in some divisions are more carefully selected than in others, or that in certain divisions the requirements as to case histories are more stringent.

Of the 135 clinical records examined and numbered, numbers 1 to 77 were regarded as satisfactory, and no notes were taken except of names, dates, diagnoses, divisions, and wards. Notes of the incomplete and unsatisfactory case records, numbered 78 to 118 and 119 to 135, respectively, are appended (names omitted).

CASE 78. Chronic valvular disease of heart.
Admitted Jan. 21, 1913. Discharged Feb. 8, 1913.
Good notes on admission; good laboratory notes; remainder of record by nurse. No discharge note.

CASE 79. Tuberculous abscess of neck.
Admitted Sept. 16, 1912. Discharged Oct. 1, 1912.
Readmission note refers to previous physical examination; date of latter not given; one clinical note Sept. 23; remainder of record by nurse; no discharge note.

CASE 80. Acute rheumatic fever.
Admitted Feb. 3, 1913. Discharged Feb. 10, 1913.
Good admission, physical examination, and laboratory notes; remainder of record by nurse.

CASE 81. Diabetes mellitus.
Admitted Sept. 16, 1912. Discharged Oct. 1, 1912.
Good record of admission and physical examination; one subsequent clinical note; remainder of record by nurse.

CASE 82. Burn of foot.
Admitted Feb. 8, 1913. Discharged Feb. 10, 1913.
Good record of admission and physical examination; remainder of record by nurse.

CASE 83. Acute rheumatic fever.
Admitted Jan. 13. 1913. Discharged Feb. 9, 1913.
Good clinical record up to Jan. 24; after that date nurse's notes only.

CASE 84. Acute bronchitis.
Admitted Sept. 17, 1912. Discharged Oct. 1, 1912.
Good record of admission and physical examination; remainder of record by nurse; broncho-pneumonia noted in caption as a complication; no notes of physical examination after initial record.

CASE 85. Carcinoma of rectum.
Admitted Jan. 27, 1913. Discharged Feb. 2, 1913.
Good record of admission and physical examination; remainder of record by nurse.

CASE 86. Myocarditis.
Admitted Jan. 20, 1913. Discharged Jan. 30, 1913.
Good record of admission and physical examination; record of sputum examination; no further notes except by nurse.

CASE 87. Acute salpingitis.
Admitted Jan. 25, 1913. Discharged Jan. 28, 1913.
Notes of admission, physical examination, and discharge not very full; remainder of record by nurse.

CASE 88. Cirrhosis of liver.
Admitted Sept. 23, 1912. Discharged Oct. 3, 1912.
Good record of admission and physical examination. Discharge note: "Patient discharged from hospital, being relieved somewhat of his distressing symptoms, but still showing all signs of his present illness." All other notes by nurse.

CASE 89. Acute rheumatic fever.
Admitted Jan. 4, 1913. Discharged Feb. 3, 1913.
Good record of admission and physical examination. One clinical note Jan. 9: "Râles persist in right base." No other mention of any lung ocmplication; remainder of record by nurse.

CASE 90. Bronchiectasis.
Admitted Feb. 2, 1913. Discharged Feb. 7, 1913.
Good record of admission and physical examination; good laboratory notes; remainder of record by nurse.

CASE 91. Acute rheumatic fever.
Admitted Jan. 30, 1913. Discharged Feb. 9, 1913.
Good record of admission, and of physical and laboratory examination; subsequent record by nurse.

CASE 92. Chronic cardiac valvular disease.
Admitted Sept. 16, 1912. Discharged Oct. 1, 1912.
Good record of admission and physical examination; all other notes by nurse.

CASE 93. Chronic cardiac valvular disease.
Admitted Nov. 27, 1912. Discharged Dec. 10, 1912.
Good record of admission and physical examination; discharge note; remainder of record by nurse.

CASE 94. Cellulitis of leg.
Admitted Sept. 15, 1912. Discharged Oct. 3, 1912.
Good record of admission, physical examination, and operation; remainder of record by nurse.

CASE 95. Chronic valvular disease of heart.
Admitted March 19, 1913. Discharged March 24, 1913.
Good record of admission and physical examination; remainder of record by nurse.

CASE 96. Chronic interstitial nephritis.
Admitted Nov. 10, 1912. Discharged Nov. 18, 1912.
Good record of admission and physical examination; good discharge note; remainder of record by nurse.

CASE 97. Chronic interstitial nephritis.
Admitted Nov. 16, 1912. Discharged Nov. 20, 1912.
Good record of admission and physical examination; remainder of record by nurse.

CASE 98. Chronic interstitial nephritis; chronic alcoholic poisoning.
Admitted Nov. 29, 1912. Discharged Dec. 2, 1912.
Good record of admission, and of physical and laboratory examinations; remainder of record by nurse.

CASE 99. Chronic interstitial nephritis; chronic alcoholism; multiple neuritis.
Admitted Nov. 25, 1912. Discharged Dec. 11, 1912.
Good record of admission, physical examination, and laboratory notes; remainder of record by nurse.

CASE 100. Chronic interstitial nephritis.
Admitted Dec. 4, 1912. Discharged Dec. 10, 1912.
Good record of admission, and of physical and laboratory examinations; remainder of record by nurse.

CASE 101. Chronic interstitial nephritis; simple anemia; general arterio-sclerosis.
Admitted Dec. 2, 1912. Discharged Dec. 9, 1912.
Good record of admission and physical examination; all other notes by nurse.

CASE 102. Chronic interstitial nephritis.
Admitted Dec. 6, 1912. Discharged Dec. 9, 1912.
Good laboratory notes; physical examination notes do not mention a wound of the head referred to in nurse's note of Dec. 6.

CASE 103. Chronic valvular disease of heart.
Admitted Nov. 4, 1912. Discharged Nov. 19, 1912.
Good notes of admission and physical examination; remainder of record by nurse.

CASE 104. Chronic valvular disease of heart.
Admitted Oct. 31, 1912. Discharged Nov. 20, 1912.
Good record of admission and physical examination; all other notes by nurse.

CASE 105. Chronic valvular disease of heart.
Admitted Nov. 24, 1912. Discharged Nov. 26, 1912.
Good record of admission, and of physical and laboratory examinations; remainder of record by nurse.

CASE 106. Chronic valvular disease of heart.
Admitted Nov. 12, 1912. Discharged Nov. 22, 1912.
"Family history—see Record Room." Date of previous treatment not given; otherwise a good case history.

CASE 107. Chronic valvular disease of heart.
Admitted Nov. 19, 1912. Discharged Nov. 25, 1912.
Good record of admission, and of physical and laboratory examinations; discharge note; all other notes by nurse.

CASE 108. Chronic valvular disease of heart.
Admitted Nov. 21, 1912. Discharged Nov. 30, 1912.
Good record of admission, physical examination, and laboratory notes; remainder of record by nurse.

CASE 109. Chronic valvular disease of heart.
Admitted Nov. 9, 1912. Discharged Dec. 2, 1912.
Good record of admission, and of physical and laboratory examinations; all other notes by nurse.

CASE 110. Lobar pneumonia.
Admitted Sept. 30, 1912. Discharged Oct. 11, 1912.
Good record of admission and physical examination; two subsequent clinical notes; rest of record by nurse.

CASE 111. Lobar pneumonia.
Admitted June 26, 1912. Discharged (date not given).
Good history except omission of date of discharge.

CASE 112. Lobar pneumonia; general septicæmia.
Admitted Sept. 23, 1912. Died Sept. 25, 1912.
Good record of admission and physical examination; all other notes by nurse.

CASE 113. Lobar pneumonia.
Admitted Oct. 18, 1912. Discharged Oct. 30, 1912.
Good record of admission, and of physical and laboratory examinations; one clinical note Oct. 20; remainder of record (after crisis) by nurse.

CASE 114. Lobar pneumonia.
Admitted Oct. 16, 1912. Discharged Nov. 7, 1912.
Good record of admission, physical examination, and laboratory notes; remainder of record by nurse.

CASE 115. Lobar pneumonia; old hemiplegia; chronic nephritis.
Admitted Nov. 7, 1912. Died Nov. 11, 1912.
Good record of admission, and of physical and laboratory examinations; all other notes by nurse. Last note Nov. 11: "Condition unchanged."

CASE 116. Lobar pneumonia.
Admitted Feb. 8, 1913. Died Feb. 12, 1913.
Good record of admission and physical examination; one subsequent clinical note (Feb. 10th) indicates that condition was serious; remainder of record by nurse.

CASE 117. Lobar pneumonia.
Admitted Jan. 24, 1913. Discharged Jan. 31, 1913.
Good record of admission, and of physical and laboratory examinations; remainder of record by nurse.

CASE 118. Lobar pneumonia.
Admitted Dec. 22, 1912. Discharged Jan. 25, 1913.
Nurse's note Dec. 22: "Examined by Dr. ——"; no record of this examination. First recorded physical examination is dated Jan. 2; case history otherwise good.

CASE 119. Subacute rheumatic fever.
Admitted Jan. 18, 1913. Discharged Jan. 23, 1913.
Readmission notes refer to previous record (date not given) for statement of patient's condition; remainder of record by nurse.

CASE 120. Contusion of jaw.
Admitted Sept. 23, 1912. Discharged Oct. 1, 1912.
Good record of admission and physical examination; X-ray record shows fracture of both bones of forearm; remainder of record by nurse. Treatment recorded is for fracture of bones of forearm. Diagnosis in caption not consistent with record.

CASE 121. Necrosis of jaw.
Admitted Jan. 28, 1913. Discharged Jan. 30, 1913.
Sufficient record of admission and physical examination; remainder of record by nurse. Record shows no basis for diagnosis of necrosis except swelling and tenderness of jaw. No special treatment recorded except a dose of oil. Condition at discharge given in caption only. No reason given for discharge.

CASE 122. Subacute rheumatic fever.
Admitted Jan. 19, 1913. Discharged Jan. 22, 1913.
Complication noted: Fibroma of Breast. Notes of admission and physical examination describe breast lesion only; "bones, joints and muscles negative;" remainder of record by nurse. The only indication in the record of the presence of rheumatic fever is the existence of fever as shown in the temperature charts and the following nurse's notes:
"Jan. 19. Pain in limbs and chest. Jan. 20. Pain in left arm and shoulder, also in right leg."

CASE 123. Abscess of kidney.
Admitted Aug. 12, 1912. Discharged Oct. 5, 1912.
Sufficient record of admission, physical examination, and operation; X-ray record; remainder of record by nurse. Result stated in caption only. Post-operative course can only be inferred from nurse's notes of "dressings changed, etc."

CASE 124. Dislocation of hip.
Admitted Jan. 7, 1913. Discharged Jan. 28, 1913.
Copy of previous history attached to clinical record gives an account of convulsive seizures and of previous treatment for same in Flower and Bellevue hospitals.
Discharge note: "Patient discharged to home. Advised to go to O. P. D. Diagnosis: Dislocation of hip. Post-operative abdomen-hysteria." Remainder of record by nurse. Beyond the nurse's notes of "pain in side" and "pain in hip," there is no reference to any condition like dislocation of the hip and no record of such dislocation or of treatment therefor except in discharge note quoted above. The case history as a whole indicates some nervous disorder.

CASE 125. Normal puerperium.
Admitted Feb. 4, 1913. Died Feb. 6, 1913.
Complications, noted in caption only: "Endocarditis, pulmonary œdema, pulmonary tuberculosis."
Admission note: "Admitted post-partum—Transferred from School of M." All other notes by nurse only.

CASE 126. Amputation of stump.
Admitted Aug. 15, 1912. Discharged Oct. 1, 1912.
Good record of admission, physical examination, and operation; remainder of record by nurse. Result stated only in caption.

CASE 127. Ventral hernia.
Admitted Sept. 16, 1912. Discharged Oct. 1, 1912.
Good record of admission, physical examination, and operation; subsequent record by nurse. Nurse's note, Sept. 27, that sutures were removed. Otherwise, result indicated only in caption.

CASE 128. Laceration of pelvic floor.
Admitted Sept. 18, 1912. Discharged Oct. 6, 1912.
Notes of admission and physical examination do not describe local condition; operation note, Sept. 25, describes curettage of uterus, and repair of lacerated cervix and lacerated perineum; subsequent record by nurse. Result stated only in caption.

CASE 129. Carcinoma of breast.
Admitted Aug. 15, 1912. Discharged Oct. 1, 1912.
Good record of admission, physical examination, and operation; subsequent notes by nurse, who recorded dressings at intervals until Sept. 28th. Result stated only in caption.

CASE 130. Tubercle of knee joint. Complication: Tubercle of vertebræ.
Admitted Sept. 10, 1912. Discharged Oct. 1, 1912.
Good record of admission and physical examination; remainder of record by nurse. Nature of local treatment not stated. Condition at discharge noted only in caption.

CASE 131. Right inguinal hernia.
Admitted Sept. 11, 1912. Discharged Oct. 2, 1912.
Good record of admission, physical examination, and operation; remainder of record by nurse. Result stated only in caption. No statement as to primary union or septic infection.

CASE 132. Carcinoma of uterus.
Admitted Sept. 9, 1912. Discharged Oct. 2, 1912.
Good record of admission, physical examination, and operation; subsequent history by nurse. Result stated only in caption. Little information can be obtained as to post-operative course.

CASE 133. Erysipelas.
Admitted Jan. 28, 1913. Discharged Feb. 2, 1913.

Admission notes scanty and scarcely legible; with difficulty it was gathered that erysipelas had followed a mastoid operation; remainder of record by nurse. Condition at discharge noted only in caption.

CASE 134. Lobar pneumonia; suppurative pleurisy; empyema; septicæmia.
Admitted Nov. 27, 1912. Died Dec. 3, 1912.

Good record of admission, physical and laboratory examinations; remainder of record by nurse. There is no mention in the body of the report of the complication noted in the caption; viz., empyema.

CASE 135. Lobar pneumonia.
Died Oct. 8, 1912.

This record gives nothing except the anatomical diagnosis as reported by the coroner. No data of any kind are given as to the circumstances of admission or death.

2. AUTOPSY FINDINGS IN BELLEVUE HOSPITAL COMPARED WITH CLINICAL DIAGNOSES

THE INVESTIGATION

Previous to the eighteenth century physicians had no knowledge of the effect of diseases on the organs of the body. Morgagni, of Italy, in the middle of the eighteenth century, and Bichat, of France, in the latter part of the same century, conceived the idea that the organs of the body were affected by diseases and that an examination of the organs would indicate the character of the disease which caused death. Their work paved the way for the brilliant work of Rokitansky, of Vienna, who worked in the middle of the nineteenth century. Virchow, of Germany, and other pathological anatomists, following in the footsteps of these earlier experimenters, have shown clearly that certain diseases have definite effects upon the internal organs, and that the degree of these effects may be determined previous to death by various methods. These methods are now familiar to all good diagnosticians. Very rapid progress has been made in the art of diagnosing because of the facts brought out by autopsies, but advance along these lines has been made much more rapidly in Europe than in America, because the hospitals in Europe are empowered to perform autopsies on nearly all bodies. In 1912 the University College Hospital, in London, performed autopsies in 84 per cent. of the deaths. Most of the hospitals in Germany perform autopsies in over 90 per cent. of deaths, and the Allgemeines Krankenhaus, in Vienna, performed autopsies in as high a percentage of deaths as 99.9 per cent.

Bellevue Hospital, on the other hand, performs autopsies in only about 10 per cent. of the deaths. Bellevue is not, however, an exception to hospitals generally in the United States. Boston City Hospital performs in about 9 per cent. and Philadelphia General Hospital in 10 per cent. of deaths. A few hospitals in the United States show a higher percentage. For instance, Johns Hopkins Hospital has performed autopsies in 62.8 per cent. of deaths.

So long as it is impossible to perform a larger percentage of autopsies medical knowledge in the United States will lag behind that of Europe, and advancement will necessarily be slow. In this country very satisfactory progress is being made in surgical knowledge and methods, and in the study of bacteriological diseases, but advance in knowledge of chronic diseases and diseases relating to a disturbed metabolism is slow. Progress along these lines will be greatly retarded by lack of opportunity to study effects upon organs and tissues of various treatments which may be administered.

Bellevue Hospital has built and equipped the finest pathological laboratory building in the United States, and probably the best in existence. It is provided with every modern facility for performing autopsies and following up such autopsies by experimental work upon tissues, but although the Hospital has provided itself with this exceptionally well-designed and thoroughly equipped building it is practically unable to use it, because of its inability to secure permission to perform autopsies.

Autopsies may be performed on any body, provided relatives of the deceased consent to an autopsy. Previous to April 15, 1910, Bellevue was enabled to perform autopsies on all bodies not claimed by relatives or

2. What is the average number of subjects now supplied to each of your students in ——— Medical School?

3. To what extent, in your opinion, are subjects upon which autopsies have been made, available, if at all, for purposes of dissection?

Replies received in answer to this communication were as follows:

Dr. George A. Piersol, University of Pennsylvania

1. The opportunity to dissect two entire bodies during his first and second years is, in my opinion, an "ample provision" for each student.

2. The student is required to dissect one entire body in the Medical School of the University of Pennsylvania. Many students, however, dissect additional parts.

Dr. F. P. Mall, Johns Hopkins Medical School

An ample supply of anatomical material should allow one whole body to each first year student.

1. On an average one-half of this should be used for the first year, and one-half for the second year of the medical course.

2. Our supply is greater than this, so we select the best subjects, and send all the bodies that have been autopsied to the Potter's Field or have skeletons made of them.

3. When it comes to the serious study of an anatomy an autopsied subject is of very little value.

4. The bulk of the study should be devoted to the head, neck, and trunk, which, of course, includes the viscera. Since a number of whole subjects have diseased viscera, it is necessary to allow the whole subject to each first year student.

Dr. R. H. Whitehead, University of Virginia

1. One lateral half of a body per student for dissecting is, in my opinion, the smallest amount allowable. In addition to the material for dissection by individual students other bodies are needed for making stock preparations, etc.

2. One body to each pair of students.

3. The utilization of subjects which have been submitted to autopsy cannot be made very effective here, because we assign an entire body to a pair of students. Where, however, the body for dissection is divided into a large number of "parts," some use can be made of such material (upper and lower extremities). At best, however, the use of such material is apt to be unsatisfactory, owing to the great trouble involved in making satisfactory embalming arterial injections, etc.

It will be noticed by reviewing the above letters that none of the anatomists holds that a student needs more than 1 body for anatomical purposes during his entire course, or half of such body for each of his first two years. Dr. Whitehead, of Virginia, states that, in his opinion, 1 lateral half for each student for the whole course is sufficient. According to the basis indicated by these anatomists, the number of bodies required by the undergraduate medical students of New York City would be about 342. During 1912 these colleges actually received 661 bodies.

The majority report above referred to contended that the hospitals should be able to secure all the material necessary from consent autopsies. The minority members of the Committee held that consent autopsies must be performed at uncertain and inconvenient hours, many times with great haste, to meet the convenience of the undertaker or friends; and that for this reason it was exceedingly difficult to use such autopsies for the purpose of instruction. These members of the committee held that autopsies per-

formed upon unclaimed bodies were the only proper basis of instruction, inasmuch as the autopsies could be held at stated and determined hours, and with such leisure as to afford ample opportunity for demonstration and instruction.

It seems that those signing the majority, and those signing the minority, reports are justified in part in their different contentions. The law seems clearly to assign the unclaimed bodies to medical schools, but, on the other hand, the law does not seem to forbid the performing of autopsies previous to the delivery of such bodies. Also, those signing the majority report seem to claim for anatomical purposes many more bodies than they need for proper instruction of students, which surplus bodies might readily have been autopsied before delivery to the colleges. In this connection reference is made to the large percentage of autopsies made in the hospitals of Europe and the marked advance in medical knowledge due in a measure thereto.

To throw further light upon the need for autopsies as a method of verifying the ante-mortem diagnoses an examination was made of the autopsy findings in Bellevue. The post-mortem findings of the autopsies performed during the year 1912 were compared with the ante-mortem or clinical diagnoses made by the physicians in each case. This comparison was made on behalf of the Committee by Dr. Horst Oertel, formerly Chief Pathologist of the Russell Sage Pathological Institute, located at City Hospital. Dr. Oertel compared the findings recorded in connection with each autopsy with the medical record and diagnosis made in the hospital previous to the death of such subject, and has placed his findings in five classes or divisions, as follows:

Class			
I.	Clinical Diagnoses confirmed	87	22.4%
II.	Clinical diagnoses correct but autopsies disclosed additional important lesions	116	29.9%
III.	Clinical diagnoses partly correct but other important lesions that had contributed to the diagnosed lesions were found	54	13.9%
IV.	Clinical diagnoses not confirmed	107	27.6%
V.	No clinical diagnoses in death records	24	6.2%
		388	100.0%

To give a clearer understanding of the type of cases included within each class the following cases are given as illustrative of the above classes:

Class I. Clinical diagnoses confirmed.

Case No. 3212.

Clinical diagnosis: Peritonitis. Acute general nephritis. Acute puerperium.

Postmortem findings: Septicemia. General suppurative peritonitis. Suppurative metritis with abscess. Acute necrotic vaginitis. Acute splenic tumor. Acute parenchymatous hepatitis and nephritis (marked). Subacute adhesive pleuritis with effusion (double). Acute congestion of lungs.

Class II. Clinical diagnoses correct but autopsies disclosed additional important lesions.

Case No. 3080.

Clinical diagnosis: Otitis media (right).

Postmortem findings: Broncho-pneumonia in apex of left lung. Acute parenchymatous nephritis. Otitis media (right).

Class III. Clinical diagnoses partly correct but other important lesions that had contributed to the main diagnosed lesions were found.

Case No. 3072.

Clinical diagnosis: Broncho-pneumonia.

Postmortem findings: Acute miliary tuberculosis. Tubercular broncho-pneumonia (left lower lobe).

Class IV. Clinical diagnoses not confirmed.

Case No. 3132.

Clinical diagnosis: Chronic interstitial nephritis.

Postmortem findings: Glanders. Acute splenic tumor. Chronic fibrous pleurisy. Hypostatic congestion, left lung. Degeneration of liver, myocardium and kidneys.

Case No. 3047.

Clinical diagnosis: Carcinoma of gall bladder.

Postmortem findings: Chronic aortitis. Serofibrinous pleurisy (left). Acute verrucous aortic valvulitis.

Class V. No clinical diagnoses in death records.

Case No. 3455.

Clinical diagnosis: None.

Postmortem findings: Dilatation and hypertrophy of right and left ventricles. Chronic myocarditis. Chronic œdema of lungs with slight pial œdema. Chronic adhesive pleuritis (right). Chronic hypostatic congestion of lungs. Chronic interstitial splenitis.

It will be observed that the above findings by Dr. Oertel show that the clinical diagnoses were confirmed in 52.3 per cent. of the cases, and that they were not confirmed in 47.7 per cent. of the cases.

Some question might be raised as to the propriety of including Class III among the diagnoses not confirmed, but inasmuch as the chief cause of death was not located or diagnosed it would seem proper to include these cases among those not confirmed.

During 1912 there were 3,170 deaths in Bellevue. If the same percentage of wrong diagnoses maintained in connection with the total number of deaths as in connection with those that were autopsied, there would have been 1,512 deaths in Bellevue from causes not fully known or rightly diagnosed. It is, of course, impossible to rightly diagnose in all cases. Outward manifestations or symptoms are often so obscure and undefined that the real cause of ailment is problematical. This may be illustrated by the findings of Dr. Richard Cabot, who, in "A Study of Mistaken Diagnoses," lists 1,761 cases wherein he compared the autopsy findings with the clinical diagnoses and data. In his presentation of the matter he divided the causes of death into about 29 classes and gave the percentages of correct and mistaken diagnoses in each class. The average percentage of correctness of the diagnoses in all of these cases, taken as a whole, was 40.3 per cent. He makes the following explanation of his methods in making comparisons:

> My comparisons, then, have been far from literal. In each case I have gone behind the recorded diagnosis and endeavored to reason out what diagnosis was justified by the facts as known during life * * * * My comparisons, then, have been made between the diagnosis warranted by the recorded clinical data and the autopsy protocols.

It appears from his statement that Dr. Cabot has not merely compared the autopsy protocols with the diagnosis appearing upon the clinical records, but has also taken into consideration the clinical data which, when interpreted, might lead to a different diagnosis from that recorded. In

other words, by interpretation he has reduced the element of error as much as possible. Had he adopted the method pursued by Dr. Oertel, wherein he compared the autopsy findings with the recorded clinical diagnoses, his percentage of errors would probably have been somewhat greater. The percentages of error recorded by Dr. Cabot, then, may be considered not far different from those found in Bellevue.

The conclusions to be drawn from the large percentage of errors in clinical diagnoses revealed in the records of Bellevue are not that the findings of the attending physicians of Bellevue are carelessly made and recorded, but rather that too great reliance is placed upon inexperienced house physicians and internes, and also that the current knowledge necessary to make clinical diagnoses which shall approach accuracy is insufficient. Not, of course, insufficient as applied merely to the attending physicians of Bellevue, since it may be supposed that they represent the best current medical knowledge. The conclusion may be legitimately drawn that medical knowledge is not sufficiently advanced to enable physicians to diagnose with great degree of accuracy.

Since autopsy findings are the chief means of correcting the mistakes of clinical diagnoses and the enlargement of knowledge of the causes and progress of diseases, it would seem of the utmost importance that as many autopsies be performed as possible, and the necessity for such autopsies would seem to be of much greater importance than the use of bodies for anatomical dissection.

It is exceedingly difficult to secure consents for autopsies from relatives and friends, and there is little hope of securing a much larger percentage of consents than at present except through the gradual education of the public to the value of, and necessity for, autopsies. It seems obvious, therefore, that efforts should be made to secure the privilege of autopsying as large a proportion as possible of the unclaimed dead. If the Commissioner of Charities has rightly interpreted the existing law unclaimed bodies cannot be autopsied, but must be distributed intact to medical colleges. Inasmuch as it seems highly probable that the medical colleges need but a small proportion of the unclaimed bodies for anatomical purposes, it would seem highly important that the existing law regulating the disposal of such bodies should be so amended as to permit accredited hospitals to perform autopsies upon the unclaimed bodies, setting aside only such a proportion for the use of the medical colleges as may be actually necessary for their rightful purposes.

The existing law provides that only the husband, wife, or next of kin of the deceased may authorize an autopsy, except in such cases as fall under the control of coroners, or some officer of the courts. No friend is authorized to permit an autopsy, and, as before stated, according to the present interpretation of the law unclaimed bodies must be distributed to medical colleges without having been autopsied.

For the advancement of medical knowledge and the protection of the living it would seem highly advisable to so amend the existing law as to provide for autopsying the largest possible proportion of bodies. To accomplish this purpose it is suggested that the existing law be amended in the following particulars:

1. That accredited hospitals be permitted to perform autopsies in all cases, except those where they are expressly forbidden to perform such

autopsy by the wife, or husband, or next of kin within 48 hours after death.

2. That autopsies be performed upon the bodies of all persons dying in public institutions, whether hospitals, prisons, reformatories, almshouses, asylums, or other institutions of a public character, unclaimed by husband, wife, or next of kin within 48 hours after death, or unless the deceased, while in the institution, has signed a request that no autopsy be performed; except such proportion of these bodies as may be necessary for the legitimate needs of medical colleges for teaching purposes.

3. DISTRIBUTION OF WARD SPACE IN BELLEVUE HOSPITAL

THE INVESTIGATION

BY

DR. L. L. WILLIAMS

A daily census of the wards in the Surgical, Gynecological, Genito-urinary, and (adult) Medical Services for the 3 months ended December 31, 1912, is the basis of the subjoined tables. An examination of these tables furnishes the following data:

In the male wards of the Medical Service, with a total capacity of 220 beds, the average percentage of vacant beds during this quarter was 25.1; in other words, these wards, in the aggregate, were three-fourths full as a rule; 56 of the 220 beds having been vacant.

In the female wards of the Medical Service, with a total capacity of 103 beds, the average percentage of vacant beds was 20.3; 17 beds, or one-sixth of the total number, having been vacant as a rule.

In the Genito-urinary Service, with a total capacity of 79 beds, the average percentage of vacant beds was 27.8; 22 beds, more than a fourth, having been vacant as a rule.

The male wards of the Surgical Service, with a total capacity of 184 beds, showed 4.1 per cent. average vacancies; 7 beds only having been vacant, as a general rule, in the entire service.

In the female wards of the Surgical Service, with a total capacity of 71 beds, the vacancies averaged 14.4 per cent.; 10 beds having usually been vacant.

In the children's wards of the Surgical Service, with a total capacity of 52 beds, instead of vacancies there was found to have been for the quarter an average of 10.4 per cent. additional beds in the wards. During the month of November one of these wards (ward 16) showed an average overcrowding of 47.1 per cent. above its normal capacity.

To summarize:

The Surgical Service, in a total of 255 beds, had, on an average, only 12 surplus beds to provide for fluctuations in admissions and discharges.

The Medical Service, in a total of 323 beds, had, on an average, 77 surplus beds to provide for fluctuations.

The Genito-urinary Service, in a total of 79 beds, had, on an average, 21 surplus beds to provide for fluctuations.

During October the male medical wards were not full at any time. During November the male medical wards of the Third Division were full on 2 occasions, the other divisions showing vacancies. During December the male medical wards in the Third Division were full on 2 occasions, the others showing vacancies.

In the female Medical Service the wards during October were full 8 times in the Second Division; 15 times in the Third Division; and 2 times in the Fourth Division. During November they were full on 2 occasions in the Second Division; 6 times in the Third Division; and 5 times in the

Fourth Division. During December they were full on 3 occasions in the Third Division.

In the Surgical Service the wards were full or showed additional beds on many days during the period covered by the inquiry, the maximum having been reached in the children's ward of the Second Division, which was full or overcrowded every day during October and November.

By reference to Tables I to VI it will be seen that these figures correspond closely with the average percentage of vacancies in the various divisions. With a view to establishing approximately a normal average percentage of vacant beds in a ward or group of wards, that is, an average of vacancies which would indicate that the ward or wards were working at approximately full capacity but without overcrowding, Table XII was constructed. It was found that wards showing average vacancies of 10 per cent. and under were full or showed additional beds 40 days in 100 days, or 40 per cent. of the time. These figures fell to 15 per cent., or 15 days in 100, in wards showing more than 10 per cent. and not more than 15 per cent. of vacancies.

In following this line of inquiry further (including the above-mentioned wards for a period of 3 months, and the wards of the Genito-urinary Service for 1 year) it was found that wards showing average vacancies of from 12 per cent. to 15 per cent. were full 14 days in 100, and that there never were more than 1 or 2 beds in excess of the normal capacity.

It may be fairly assumed that an average of 12 per cent. vacancies is approximately normal; that is, that wards showing such an average of vacancies would never be objectionably crowded, and that wards showing an average of more than 15 per cent. vacancies are not running at their full capacity, the ward space not being utilized to the best advantage.

These data clearly show that, while the wards of the Surgical Service were congested during this period, the wards of the Medical and Genito-urinary Services contained numerous vacant beds. The ward space as between these services therefore is not equitably divided, and the figures suggest the propriety of a rearrangement of the wards with a view to preventing a chronic congestion in the Surgical Service. The latter evidently needs more room.

There is not only great variation in the relative amount of ward space allotted to the several services, so that one is overcrowded while another has abundant space, but there are local congestions in a service. A few instances will suffice to show this. Reference to Tables IX, X, and XI will show this local congestion in certain wards in the Surgical Service, one division requiring additional beds, while other divisions had vacant beds.

The conditions presented, therefore, were:

1. Certain services running at practically the full capacity of the wards, with periods of overcrowding, while in other services the wards were only partly full.

2. In a service overcrowding was shown in one division, while similar wards in other divisions were partly vacant.

It can scarcely be contended that this was an economical allotment of ward space. At the same time, this failure to utilize space to the best advantage was not traceable to dereliction on the part of any one individual, but rather to the peculiarities of the system of administration of the ward service.

With the exception of a few independent services—Alcoholic, Maternity, etc.—the various services are divided more or less evenly among the four divisions. Each of these divisions possesses its own separate visiting staff and house staff, and is, in effect, a separate hospital organization in so far as its medical administration is concerned. Except at night, when admissions are few, patients are admitted in rotation to these divisions without regard to whether or not the wards of one division are more crowded than those of another. In addition, visiting physicians and surgeons are permitted to send to their respective divisions so-called "private patients." These are usually patients who have been under treatment by them in one or other of the public dispensaries.

There is no transfer of patients from the wards of one division to those of another division, except under certain rare conditions. Once admitted to a division a patient stays in that division until his discharge from the Hospital. Each division is sufficient to itself, using the material in its own wards for teaching purposes, and neither permitting the visiting staffs of other divisions to use the material in its wards nor itself infringing upon the preserves of the others. Under this rigid system, with each division jealously guarding its rights, and taking into consideration the inevitable fluctuation in the length of stay of patients in the wards, the occurrence of local overcrowding is easily explained. And such conditions are bound to continue as long as power is vested in no one of the officers of the Hospital to forbid admissions to crowded wards when space is available elsewhere, and to compel the transfer of patients from congested wards to others with vacant beds.

Several solutions suggest themselves. Partial relief may be obtained by authorizing some officer of the Hospital, preferably the Superintendent, who is not affiliated with any of the divisions, to exercise control over the admission and distribution of patients, admitting them to the appropriate services according to vacancies in wards. This involves the abrogation of the inelastic rule regarding rotation.

A second solution would include the above and, in addition, the establishment of a fifth division, officered by a paid resident staff, into which patients no longer useful as teaching material could be transferred from the other divisions. This plan would involve empowering the Superintendent to effect transfers between divisions. It would also curtail the space now allotted to the existing divisions.

A third and more radical plan offers the most complete solution. This would involve the abolition of the present divisional lines and the consolidation of the several services now distributed among four divisions. Under this plan there could be no undue overcrowding in a single ward in any given service while other wards of the same kind are partly vacant; because all the surgical wards would be grouped together, all the medical in one group, etc. There being no divisional line separating one ward of a given group from another ward of the same group, admitted cases would naturally be placed in vacant beds in any ward of the group as a matter of convenience in administration.

As the administration of the Hospital under this plan would have a free hand in distributing patients to the best advantage, it would be practicable when one service, the surgical for instance, became overcrowded to temporarily transfer to the Surgical Service a ward belonging to a different service, provided the latter showed such a percentage of vacancies as would

admit of such a change. Temporary fluctuations as between different services or departments of the Hospital could thus be easily provided for, and the entire available space utilized to the best advantage, with the minimum of overcrowding in any department. The last suggestion, however, may be impracticable under existing conditions.

The most plausible argument which can be brought against any of these suggested plans is that it would disturb the *status quo* as between the Hospital and the medical schools, and be inconvenient to the latter. These schools should have every facility in Bellevue that is compatible with the public interest, but the efficiency of Bellevue as an institution for the care of the sick is paramount to all other considerations, and there is no doubt that, if a question should arise as between the best interests of the dependent sick on the one hand and the interests of the medical schools on the other, the latter would be willing to give way. There is no question that the connection between a medical school and a hospital is of mutual benefit, and the schools should have every encouragement to make full use of the clinical material in Bellevue. They should not expect, however, to retain privileges which are not compatible with the highest usefulness of the institution, nor can the City with advantage to its finances or its patients turn over to the schools practically complete control of the administration of the wards of its largest municipal hospital. That the visiting and house staffs should have complete control of the treatment of patients is, of course, conceded, but the admission, discharge, and distribution of patients are administrative functions which the City should control through its permanent salaried officials.

TABLE I.

PERCENTAGES OF VACANCIES IN WARDS.

MEDICAL SERVICE—MALE WARDS.

1912	Division I Capacity 58 beds		Division II Capacity 58 beds		Division III Capacity 46 beds		Division IV Capacity 58 beds		
	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	
October	36.0	20.9	23.8	13.8	19.3	8.9	30.5	17.7	Total number of Wards 8
November	47.9	27.9	13.5	7.3	13.0	6.0	24.5	14.2	Total capacity 220 beds
December	48.3	28.4	15.9	8.6	9.1	4.2	18.8	10.9	Average per cent. vacancies 25.1
Average	44.3	....	17.7	....	13.8	....	24.6	....	Average number vacant beds 56.2

TABLE II.

PERCENTAGES OF VACANCIES IN WARDS.

MEDICAL SERVICE—FEMALE WARDS.

1912	Division I Capacity 32 beds		Division II Capacity 26 beds		Division III Capacity 19 beds		Division IV Capacity 26 beds		
	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	
October.....	42.2	13.5	9.6	2.5	4.2	.8	18.8	4.9	Total number of Wards 8
November.....	43.1	13.8	20.0	5.2	10.5	2.0	15.4	4.0	Total capacity 103 beds
December.....	36.6	11.7	23.5	6.1	6.8	2.3	12.7	3.3	Average per cent. vacancies 20.3
Average.....	40.6	....	17.7	....	7.2	....	15.6	....	Average number vacant beds 17.3

TABLE III.

PERCENTAGES OF VACANCIES IN WARDS.

GENITO-URINARY SERVICE—MALE WARDS.

1912	Division I Capacity 18 beds		Division II Capacity 25 beds		Division III Capacity 18 beds		Division IV Capacity 18 beds		
	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	
October.....	23.9	4.3	22.4	5.6	36.1	6.5	28.9	5.2	Total number of Wards 4
November.....	13.3	2.4	24.4	6.1	31.7	5.7	36.7	6.6	Total capacity 79 beds
December.....	19.4	3.5	34.4	8.6	33.3	6.0	28.9	5.2	Average per cent. vacancies 27.8
Average.....	18.9	....	27.1	....	33.7	....	31.5	....	Average number vacant beds 21.9

TABLE IV.

PERCENTAGES OF VACANCIES IN WARDS.

SURGICAL SERVICE—MALE WARDS.

1912	Division I Capacity 48 beds		Division II Capacity 41 beds		Division III Capacity 44 beds		Division IV Capacity 51 beds		Total number of Wards 8
	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Total capacity 184 beds
October.....	8.1	3.9	3.7	1.5	10.2	4.5	6.1	3.1	Average per cent. vacancies 4.1
November.....	2.5	1.2	.5	.2	5.5	2.4	*2.1	1.1	Average number vacant beds 7.5
December.....	.2	.1	.2	.1	7.7	3.4	*1.8	.9	
Average.....	3.6	....	1.5	....	7.8	....	3.3	....	

* Indicates excess of patients.

TABLE V.

PERCENTAGES OF VACANCIES IN WARDS.

SURGICAL SERVICE—FEMALE WARDS.

1912	Division I Capacity 18 beds		Division II Capacity 18 beds		Division III Capacity 20 beds		Division IV Capacity 15 beds		Total number of Wards 4
	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Total capacity 71 beds
October.....	17.2	3.1	13.9	2.5	24.5	4.9	9.3	1.4	Average per cent. vacancies 14.4
November.....	9.4	1.7	16.1	2.9	21.0	4.2	8.7	1.3	Average number vacant beds 10.6
December.....	7.2	1.3	15.0	2.7	27.5	5.5	2.7	.4	
Average.....	11.3	....	15.0	....	24.3	....	6.9	....	

TABLE VI.

PERCENTAGES OF VACANCIES IN WARDS.

SURGICAL SERVICE—CHILDREN'S WARDS.

1912	Division I Capacity 15 beds		Division II Capacity 14 beds		Division III Capacity 17 beds		Division IV Capacity 6 beds		Total number of Wards 4
	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Percentage of Vacancies	Average Number of Vacant Beds	Total capacity 52 beds
October.....	*6.7	*1.0	*25.0	*3.5	....	....	13.3	.8	Average per cent. excess patients 10.4
November.....	*8.0	*1.2	*47.1	*6.6	12.4	2.1	*6.6	.4	Average number excess patients 3.1
December.....	20.0	4.2	7.1	1.0	22.3	3.8	....	....	
Average.....	1.7	....	*21.7	....	11.6	....	4.4	....	

* Indicates excess of patients.

TABLE VII.

COMPARISON OF VACANCIES IN MALE MEDICAL AND SURGICAL WARDS, DIVISION I.

December, 1912	Wards A4 and B4 Capacity 58		Wards 8 and 9 Capacity 48		
	Census	Vacant beds	Census	Excess	Vacant beds
1	22	36	47	..	1
2	21	37	48	..	..
3	26	32	50	2	..
4	25	33	52	4	..
5	27	31	49	1	..
6	26	32	46	..	2
7	28	30	45	..	3
8	31	27	43	..	5
9	31	27	41	..	7
10	28	30	48	..	..
11	31	27	47	..	1
12	31	27	51	3	..
13	27	31	50	2	..
14	29	29	50	2	..
15	32	26	51	3	..
16	32	26	50	2	..
17	32	26	51	3	..
18	34	24	47	..	1
19	30	28	48	..	..
20	30	28	47	..	1
21	31	27	50	2	..
22	31	27	47	..	1
23	29	29	46	..	2
24	30	28	49	1	..
25	31	27	47	..	1
26	30	28	47	..	1
27	31	27	48	..	..
28	30	28	50	2	..
29	32	26	48	..	..
30	32	26	45	..	3
31	37	21	48	..	..
	Average vacancies 48.3%		Average vacancies .2%.		

TABLE VIII.

VACANCIES IN WARDS, OCTOBER–DECEMBER, 1912.

SUMMARY.

Surgical Service:	
Total Capacity	255 beds
Average Vacancies	12 beds
Medical Service:	
Total Capacity	323 beds
Average Vacancies	77 beds
Genito-urinary Service	
Total Capacity	79 beds
Average Vacancies	21 beds

TABLE IX.

LOCAL OVERCROWDING IN DIVISIONS OF THE SAME SERVICE.

SURGICAL SERVCE—MALE WARDS.

December, 1912	Division I Wards 8 and 9 Capacity 48			Division II Wards 13 and 14 Capacity 41			Division III Wards 2 and 3 Capacity 44			Division IV Wards 17 and 40 Capacity 51		
	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds
12th	51	3	...	43	2	...	36	...	8	50	...	1
13th	50	2	...	40	...	1	35	...	9	53	2	...
14th	50	2	...	42	1	...	38	...	6	53	2	...
15th	51	3	...	40	...	1	40	...	4	52	1	...
16th	50	2	...	39	...	2	36	...	8	51	..	...
17th	51	3	...	42	1	...	39	...	5	53	2	...

TABLE X.

LOCAL OVERCROWDING IN DIVISIONS OF THE SAME SERVICE.

SURGICAL SERVICE—CHILDREN'S WARDS.

October, 1912	Division I Ward 7 Capacity 15			Division II Ward 16 Capacity 14			Division III Ward 1 Capacity 17			Division IV Ward 12 Capacity 6		
	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds
16th	17	2	...	18	4	...	18	1	...	4	...	2
17th	17	2	...	17	3	...	17	...	...	3	...	3
18th	17	2	...	16	2	...	18	1	...	3	...	3
19th	14	...	1	17	3	...	17	...	...	4	...	2
20th	16	1	...	17	3	...	17	...	...	4	...	2
21st	17	2	...	18	4	...	17	...	...	4	...	2
22nd	17	2	...	20	6	...	17	...	...	3	...	3
23rd	18	3	...	20	6	...	16	...	1	4	...	2
24th	18	3	...	22	8	...	16	...	1	4	...	2
25th	17	2	...	21	7	...	16	...	1	5	...	1

TABLE XI.

LOCAL OVERCROWDING IN DIVISIONS OF THE SAME SERVICE, SURGICAL SERVICE—CHILDREN'S WARDS.

November, 1912	Division I Ward 7 Capacity 15			Division II Ward 16 Capacity 14			Division III Ward 1 Capacity 17			Division IV Ward 12 Capacity 6		
	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds	Census	Excess Patients	Excess Beds
9th	12	...	3	24	10	...	15	...	2	8	2	...
10th	12	...	3	24	10	...	15	...	2	9	3	...
11th	11	...	4	24	10	...	15	...	2	8	2	...
12th	12	...	3	22	8	...	16	...	1	7	1	...
13th	13	...	2	23	9	...	17	...	...	8	2	...

TABLE XII.

AVERAGE PERCENTAGE OF VACANCIES IN WARDS COMPARED WITH THE NUMBER OF DAYS WHEN SAME WARDS WERE FULL OR OVERCROWDED.

Average Percentage of Vacancies	Total Number of Days	Number of Days Wards Were Full	Number of Days Per 100 When Wards Were Full
5% and under	367	149	40
From 5% to 10%	461	187	40
From 10% to 15%	304	47	15
From 15% to 20%	491	30	6
From 20% to 25%	215	5	2
From 25% to 30%	123	1	1
From 30% to 35%	154	3	1
From 35% to 40%	92	...	...
From 40% to 45%	61	...	...
From 45% to 50%	91	...	...
From 12% to 15%	305	44	14*

* The maximum additional beds were 2 beds on 4 occasions.

4. TRANSFER OF PATIENTS TO AND FROM BELLEVUE HOSPITAL AND TO AND FROM KINGS COUNTY HOSPITAL

GENERAL STATEMENT

An examination has been made of the transfers to and from Bellevue Hospital, and to and from Kings County Hospital, with a view of determining to what extent the beds of these Hospitals, and more especially Bellevue, are occupied by patients that remain too short a time for any adequate treatment. The admission and discharge of these patients require much clerical and other labor, and inasmuch as these patients receive no adequate treatment before transfer from one hospital to another, it would seem that much-needed space is thus occupied, and much additional labor is performed, without securing curative results.

To determine the extent to which such transferring is carried on the records of these two Hospitals were examined for the 3 months of October, November, and December, 1911. From the records was copied information which indicated the place from which each patient was removed; the ambulance transferring each patient to Bellevue or Kings County Hospital; time of arrival in the Hospital; admission and diagnosis; time of discharge; and institution to which the discharge was made. The data has been compiled under two main headings: first, relating to the patients transferred to these Hospitals, of which there were 1,597 to Bellevue and 172 to Kings County Hospital; second, relating to the patients transferred from these Hospitals, of which there were 1,723 from Bellevue Hospital and 562 from Kings County Hospital.

The data has been arranged in the form of tables, which set forth the transfers grouped as follows:

Medical—acute and chronic
Fractures
Other Surgical Cases
Genito-urinary
Gynecological
Obstetrical
Children
Alcoholics
Insane
Tuberculosis
Contagious Diseases

In the acute medical class have been placed all the cases that did not clearly appear to be chronic medical, or to fall into one of the other classes. A close inspection of the records might alter the number of cases in this class. The surgical cases have been divided into two classes; namely, fractures and other surgical cases. The other classes are obvious.

THE INVESTIGATION

Transfer of Patients to and from Bellevue Hospital

Patients Received

For the 3 months ended December 31, 1911, 1,597 patients were received at Bellevue Hospital from other hospitals in Manhattan and The Bronx. Almost all of these came from seven hospitals: Flower, New York, House of Relief, St. Vincent, Presbyterian, Gouverneur, and Reception, and most of them came from the first four hospitals. Of the total number of patients, 428, or 26.8 per cent., came direct from these various hospitals to Bellevue; 592, or 37.1 per cent., from their residences; 472, or 29.5 per cent., were picked up in the streets; and 105, or 6.6 per cent., came from police stations. These figures appear in Table I on an accompanying page.

Character of Sickness

Of the 1,597 patients transferred to Bellevue, the alcoholics constituted the most numerous class, there having been a total of 433, or 27.1 per cent.; 95, or 6 per cent., were classed as insane; 176, or 11.1 per cent., as tuberculous; 387, or 23.6 per cent., were medical cases; and 362, or 23.3 per cent., surgical cases. The other 144, or 9 per cent., were cases of a miscellaneous character. The details for the various hospitals will be found in Table II.

Disposition of Cases

Of the 1,597 patients transferred to Bellevue, 970, or 60.7 per cent., were discharged to their homes; 329, or 20.5 per cent., were transferred to the institutions of the Department of Public Charities on Blackwell's Island; 131, or 8.2 per cent., were transferred to various institutions, most of them to hospitals for the insane; and 167, or 10.5 per cent., died at the Hospital. Omitting those from one or two hospitals, the death rate was considerably less than 10 per cent.

Length of Stay in Bellevue

The details in regard to the length of stay will be found in Table III, which shows the length of stay by character of sickness, and by disposition.

It appears from this table that 112 patients, or 7 per cent., were discharged the same day received; 165, or 10.3 per cent., were discharged the day after; 562, or 35.2 per cent., were discharged in from 2 to 4 days—a total of 52.2 per cent. that remained in Bellevue less than 4 days.

Of the 970 patients discharged to their homes, 154, or 15.9 per cent., were discharged within 24 hours; 340, or 35 per cent., were discharged in

from 2 to 4 days—a total of 50.9 per cent. that remained less than 4 days. Of the 329 discharged to the Blackwell's Island institutions, 81, or 24.8 per cent., were transferred within 24 hours; 110 were transferred in from 2 to 4 days—showing that nearly 50 per cent. of those transferred to Blackwell's Island were transferred within 4 days.

The total death rate among the patients was 10.5 per cent. or 167 of the total number received. Of these, 16 patients died the same day received; 24 others died within 1 day; and 52 others, or 31.1 per cent. of the total, died within 4 days. This would seem to indicate that a number of cases had been transferred in a very critical condition, or that the distance of transfer had a serious effect on the patient's illness. The latter is apparently brought out by the fact that the death rate was largest among the patients coming from the northern part of Manhattan. If the patients from two hospitals situated north of 59th Street are eliminated from the figures, the death rate would have been less than 9 per cent., a normal death rate for hospital cases.

Transfer of Patients from Bellevue Hospital

The number of patients transferred from Bellevue Hospital during the 3 months under consideration, including Bellevue cases, was 1,723. Of these, 1,317 originated in Bellevue, and 406 came from other hospitals. (Table IV.)

Character of Sickness

Of these 1,723 patients, 680 were classed as insane and 435 as tuberculous, or 64.6 per cent. of the total number. Of the other patients, 207 were chronic medical cases, and the others were medical and surgical cases of a general character, including some children and alcoholics. Of the total, 73 were transferred the same day they were received and 34 others were transferred within 24 hours, making a total of 107 patients transferred the same day they were received or the day after. In addition, 863, or 50 per cent. of the total, were transferred within 4 days. Of these, 432 were classed as insane; 285 as tuberculous; and 146 as medical, surgical, and other miscellaneous cases. (Table V.)

During the 3 months 487 cases, exclusive of tuberculosis, were transferred to the institutions on Blackwell's Island. Of these cases, 65 were transferred within 24 hours after being received at Bellevue, and 115 others within 4 days; that is, a total of 180 patients, or 36.9 per cent. of those transferred to Blackwell's Island, remained in Bellevue less than 4 days. (Table VI.) The chronic medical constituted the largest class of those transferred, having been 42 per cent. of the total. The others were medical and surgical cases of a general character, including 48 cases classed as alcoholics.

Changes in the Practice of Transferring Patients

It may be assumed that the transfer of patients from one hospital to another is undesirable, and should be avoided as much as possible. Aside from special classes of cases which can best be cared for in a special department connected with a large central institution the aim should be to place a sick person at once in the institution where permanent care is to be given. If this general statement is correct, the present practice of trans-

ferring patients to Bellevue and then retransferring them to institutions on Blackwell's Island should be modified in several respects.

The analysis in Table VI shows that of the 1,723 patients transferred from Bellevue in the 3 months under consideration 680 were classed as insane. As special provisions have been made at Bellevue for the examination and temporary care of the alleged insane before their commitment to insane hospitals, the transfer of this class of patients first to Bellevue and then to the State hospitals for the insane cannot be avoided.

Tuberculous patients form another large class of those transferred, 435 having been transferred in the 3 months, 79 of whom had been received from other hospitals, and 356 were Bellevue cases. It was found that 285, or 65.5 per cent. of the total, remained in Bellevue less than 4 days, and 88, or 20.2 per cent., from 5 to 9 days. This indicates that no attempt is made to give permanent care to this class of patients at Bellevue Hospital, and, excepting those whose condition is such as to require immediate care, such patients should be transferred direct to Metropolitan Hospital. This would reduce the number kept at Bellevue, and thus provide room for other classes of cases.

Excepting tuberculosis cases, 487 patients were transferred from Bellevue to Blackwell's Island. Of these, the chronic medical constituted the most numerous class, with 207 cases. Apparently this class of patients is given only temporary relief at Bellevue before being transferred, as indicated by the fact that 19 were transferred the same day they were received at Bellevue or the day after. There were 52 transferred in from 2 to 4 days, and 56 in from 5 to 9 days. Of these 108 cases, only 38 came from other hospitals, and 70 were Bellevue cases. Of the acute medical, 43 cases were transferred within 9 days, of which 8 came from other hospitals. Of the fracture cases, 37 were transferred within 9 days, 12 of which came from other hospitals. Of the whole number of cases, over 250 were Bellevue patients; the rest were patients received at Bellevue from other hospitals and retransferred to Blackwell's Island institutions.

The main reason for the transfer of these patients must be sought in the overcrowded condition at Bellevue, which necessitates the transfer of many patients after a few days treatment so as to make room for other patients needing immediate care. To avoid the numerous transfers from Bellevue, as many as possible of the patients who ultimately go to Blackwell's Island for permanent care and treatment should be sent there directly without first being admitted to Bellevue.

This direct transfer of patients from hospitals to Blackwell's Island institutions applies especially to chronic medical cases. Some of these may be in such condition as to require immediate care, but the majority of them could just as well be transferred direct from the various hospitals to Blackwell's Island. The patients in this class received at Bellevue should be transferred at once to Blackwell's Island, so far as their condition will permit. Suitable regulations could be drawn up and sent to the various hospitals transferring patients to Bellevue, defining in a general way the class that should be sent to Bellevue and those that should be sent direct to Blackwell's Island. The cases sent to Bellevue should include only such acute cases as require immediate medical care and attention.

An exception to this general rule may be made for the patients transferred from the northern part of Manhattan. An examination of Table I shows that 407 cases were transferred from Flower Hospital, and 121 from

the Presbyterian Hospital, during the 3 months. The death rate among these from the former hospital was 17.7 per cent., and from the latter 11.6 per cent., either of which being higher than was found among the patients coming from other hospitals; this can be partly explained by the fact that these patients are transferred a greater distance. However, it does not seem wise to transfer most of these patients to Bellevue, alcoholics and alleged insane excepted, and then retransfer them to Blackwell's Island so long as they may be transferred direct to Blackwell's Island by the 70th Street Ferry. This ferry is now used for the transfer of many patients from the small Reception Hospital at the foot of East 70th Street and the ambulance district attached thereto, and is found to work fairly well. It should be used also for the transfer of patients from the upper part of Manhattan, so as to avoid the long transportation to Bellevue.

The suggested modifications in the practice of transferring patients include, then, the direct transfer to Blackwell's Island institutions of: first, tuberculous patients, excepting those in a critical condition; second, chronic medical and other classes of patients, in accordance with regulations to be sent to the various hospitals; third, all patients from the northern part of Manhattan, alcoholics and insane excepted, who can be sent to the Reception Hospital and transferred by the 70th Street ferry.

Transfer of Patients to and from Kings County Hospital

Patients Received

The number of patients transferred to Kings County Hospital from other hospitals in Brooklyn and Queens for the 3 months under consideration was 172. Of this number, 68, or nearly 40 per cent., came from Bradford Street, Coney Island, and Cumberland Street Hospitals, which are under the jurisdiction of the Department of Public Charities. The other 60 per cent. came from the various private hospitals of the boroughs. The greatest number from any one of these latter, 16, came from Williamsburgh Hospital. (Table VIII.)

Character of Sickness

Of these 172 patients received at Kings County Hospital, 61, or 35.5 per cent., were classed as alcoholics; 14 as tuberculous; and 3 as insane—a total of 78, or 45.3 per cent. of the whole number. The other 94 patients were mainly medical and surgical cases. (Table IX.)

Disposition of Cases

The disposition of these patients was as follows: 98, or 57 per cent., were discharged to their homes; 47, or 27.3 per cent., died; 11, or 6.4 per cent., were sent to the City Home, Brooklyn; 9, or 5.2 per cent., were retransferred within Kings County Hospital; and 7 were sent to various institutions.

Length of Stay in Kings County Hospital

The average length of stay of these patients at Kings County Hospital was 23 days. Of the total number, however, 9 remained only 1 day before being discharged; 64, or 37.2 per cent., remained from 2 to 4 days; and 33, or 19.2 per cent., from 5 to 9 days. Of the 47 that died, 4 had been in the Hospital but 1 day before death occurred; 6 died within 48 hours; and 10 others within 4 days, aggregating 42.6 per cent. of the total number of deaths. (Table IX.)

Transfer of Patients from Kings County Hospital

In all, 562 patients were transferred from Kings County Hospital in the 3 months ended December 31, 1911. Of this total, 289, or 51.4 per cent., were classed as insane and transferred to insane hospitals; 59, or 10.5 per cent., were tuberculous patients and transferred to Metropolitan Hospital (Table X). Of the other 214 patients, 193 were transferred to the Home for the Aged and Infirm, Brooklyn, and 21 to miscellaneous institutions (Table XI).

Transfers to the Home for the Aged and Infirm

Of the 193 patients transferred to the Home for the Aged and Infirm, 116 were general medical and surgical cases, mainly chronic medical; 26 were classed as alcoholic; and 51 were put down as "non curata." Of these "non curata" cases 44 were transferred to the Home within 1 day; 3 remained from 5 to 9 days before transfer; and 2 remained over 10 days. (Table XI.)

Two features stand out prominently from the facts as stated above. One is the unusually large death rate among patients transferred to Kings County Hospital, and the other is the large number of cases transferred from Kings County Hospital to the Home for the Aged and Infirm in Brooklyn.

As already stated, there was a death rate of 27.3 per cent. among the patients received at Kings County Hospital from other hospitals in Brooklyn and Queens. The death rate among the 1,597 patients transferred to Bellevue in the same period was 10.5 per cent., and, omitting those coming from one hospital, the rate among 1,190 was less than 8 per cent. The average death rate among hospital patients varies, roughly, from 7 to 9 per cent. A death rate of 27.3 per cent. is, therefore, abnormal. Of the 21 cases classed as acute medical 10 died, or about one-half; and of the 14 tuberculous patients 9 died, or nearly two-thirds (Table VIII). The facts stated lead to one of two conclusions: *Either the patients are dangerously ill when transferred, or else the transfer for a long distance has a very aggravating effect on the illness of the patients. In either case steps should be taken to prevent the transfer of at least some of these patients.*

Among the 193 cases transferred to the Home for the Aged and Infirm 51 were classed as "non curata," that is, patients apparently in no need of medical attention. Of these, 44 were transferred within 1 day. Of the 116 medical and surgical cases transferred to the City Home, 12 were transferred within 1 day and 34 others in 2 to 4 days (Table XI). There is nothing shown in the analysis so far made to indicate whether these cases were proper cases for admission to the Home, but, if they were, they

should have been admitted direct, and not through the Kings County Hospital. There were upward of 100 of apparently improperly admitted patients occupying beds in the Hospital which should have been for hospital cases, and a strict medical examination should be instituted to avoid admitting to the Hospital as many of this class of cases as possible.

In regard to the 59 cases of tuberculosis transferred to Metropolitan Hospital it may be noted that 30 had been in the Hospital 10 or more days, and 17 from 5 to 9 days. This would indicate that Kings County Hospital is used not as a reception ward for the temporary care and treatment of acute tuberculosis cases, as it should be. A more rapid transfer of these cases would seem advisable, or, better still, a direct transfer from other hospitals or from the residences of these patients to Metropolitan Hospital.

TABLE I.

BELLEVUE HOSPITAL.

SOURCES AND DISPOSITION OF PATIENTS TRANSFERRED TO BELLEVUE HOSPITAL FROM VARIOUS HOSPITALS DURING THE THREE MONTHS ENDED DECEMBER 31, 1911.

The first section of this table shows the numbers and percentages of the patients transferred to Bellevue Hospital by the ambulances of the Hospitals indicated and whether they came direct from a hospital, from a residence, from the street, or from a police station. The second section shows what became of these patients when discharged from Bellevue Hospital.

Hospital	Sources					Disposition					
	Residence	Hospital	Street	Police Station	Total	Residence	Blackwell's Island	State Hospitals	Other Institutions	Died	Total
Flower.....	232	20	116	39	407	246	53	19	17	72	407
New York....	147	29	155	18	349	245	55	10	6	33	349
House of Relief	15	197	32	13	257	158	78	1	8	12	257
St. Vincent's..	102	32	96	12	242	130	74	14	1	23	242
Presbyterian..	47	22	44	8	121	82	18	6	1	14	121
Gouverneur...	29	48	10	12	99	36	36	20	1	6	99
Reception.....	18	26	17	3	64	52	..	6	2	4	64
All others.....	2	54	2	..	58	21	15	15	4	3	58
Totals.....	592	428	472	105	1,597	970	329	91	40	167	1,597
	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.	Per Cent.
Flower.....	57.0	4.9	28.5	9.6	100	60.4	13.0	4.7	4.2	17.7	100
New York....	42.1	8.3	44.4	5.2	100	70.2	15.8	2.9	1.7	9.4	100
House of Relief	5.8	76.6	12.5	5.1	100	61.5	30.4	.4	3.1	4.6	100
St. Vincent's..	42.1	13.2	39.7	5.0	100	53.7	30.6	5.8	.4	9.5	100
Presbyterian..	38.8	18.2	36.4	6.6	100	67.8	14.9	4.9	.8	11.6	100
Gouverneur...	29.3	48.5	10.1	12.1	100	36.4	36.4	20.2	1.0	6.0	100
Reception.....	28.1	40.6	26.6	4.7	100	81.2	...	9.4	3.1	6.3	100
All others.....	3.4	93.1	3.5	...	100	36.2	25.9	25.9	6.9	5.1	100
Totals.....	37.1	26.8	29.5	6.6	100	60.7	20.6	5.7	2.5	10.5	100

TABLE II.

Bellevue Hospital.

Classification of Patients Transferred to Bellevue Hospital from Other Hospitals During the Three Months Ended December 31, 1911.

This table groups the patients according to their diseases at the time of transfer to Bellevue Hospital and upon the final disposition of their cases.

	Medical		Surgical										
	Acute	Chronic	Fractures	Other Cases	Genito-urinary	Gynecological	Obstetrical	Children	Alcoholic	Insane	Tuberculosis	Contagious	Totals
Received from													
Residence....	100	95	27	63	6	14	46	23	96	37	84	1	592
Hospital.....	50	46	57	68	4	6	7	12	86	29	60	3	428
Street.....	50	26	75	55	6	4	6	3	199	21	26	1	472
Police station.	10	10	8	9	...	...	...	2	52	8	6	..	105
Totals.....	210	177	167	195	16	24	59	40	433	95	176	5	1597
Discharged to													
Residence....	128	68	109	141	9	19	56	32	371	3	33	1	970
City Hospital.	22	37	22	17	4	4	1	1	11	1	...	...	120
Met. Hosp...	10	22	15	21	2	...	...	2	9	...	91	...	172
City Home...	5	20	1	2	1	...	...	...	8	...	...	...	37
State Hosp's.	...	...	...	...	...	...	...	...	...	91	...	...	91
Other institutions.....	4	2	5	5	...	...	1	...	9	...	10	4	40
Died.....	41	28	15	9	...	1	1	5	25	...	42	...	167
Totals.....	210	177	167	195	16	24	59	40	433	95	176	5	1597

TABLE III.

Bellevue Hospital.

Length of Stay by Character of Disease and Disposition of Patients Transferred to Bellevue Hospital from Other Hospitals During the Three Months Ended December 31, 1911.

The first section of this table shows the patients according to their classification and the length of their stay in Bellevue Hospital, in numbers and percentages; and the second section shows the disposition of the patients according to the length of their stay in Bellevue Hospital, in numbers and percentages.

Character of Disease

	0 day		1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent.
Acute Medical	19	9.1	23	11.0	49	23.3	41	19.5	78	37.1	210	100
Chronic Medical	20	11.3	8	4.5	46	26.0	35	19.8	68	38.4	177	100
Fractures	11	6.6	7	4.2	20	12.0	39	23.3	90	53.9	167	100
Other Surgical	29	14.9	20	10.2	61	31.3	36	18.5	49	25.1	195	100
Genito-urinary	3	18.7	4	25.0	1	6.3	2	12.5	6	37.5	16	100
Gynecological	3	12.5	2	8.3	4	16.7	3	12.5	12	50.0	24	100
Obstetrical	3	5.1	3	5.1	5	8.5	16	27.1	32	54.2	59	100
Children	1	2.5	1	2.5	10	25.0	2	5.0	26	65.0	40	100
Alcoholic	16	3.7	78	18.0	221	51.0	77	17.8	41	9.5	433	100
Insane	...	....	3	3.1	47	49.5	24	25.3	21	22.1	95	100
Tuberculosis	7	4.0	15	8.5	95	54.0	31	17.6	28	15.9	176	100
Contagious	...	....	1	20.0	3	60.0	...	....	1	20.0	5	100
Totals	112	7.	165	10.3	562	35.2	306	19.2	452	28.3	1,597	100

Disposition of Patients

	0 day		1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent.
Residence	28	2.9	126	13.0	340	35.0	187	19.3	289	29.8	970	100
City Hospital	30	25.0	3	2.5	26	21.7	18	15.0	43	35.8	120	100
Metropolitan Hospital	31	18.0	7	4.1	73	42.4	29	16.9	32	18.6	172	100
City Home	7	18.9	3	8.1	11	29.8	6	16.2	10	27.0	37	100
Other institutions	...	....	2	1.5	60	45.8	33	25.2	36	27.5	131	100
Died	16	9.6	24	14.4	52	31.1	33	19.7	42	25.2	167	100
Totals	112	7.0	165	10.3	562	35.2	306	19.2	452	28.3	1,597	100

TABLE IV.

BELLEVUE HOSPITAL.

NUMBER AND CLASSIFICATION OF PATIENTS TRANSFERRED FROM BELLEVUE HOSPITAL DURING THE THREE MONTHS ENDED DECEMBER 31, 1911.

CASES ORIGINATING IN BELLEVUE HOSPITAL

Source	Medical		Surgical										
	Acute	Chronic	Fractures	Other Cases	Genito-urinary	Gynecological	Obstetrical	Children	Alcoholic	Insane	Tuberculosis	Contagious	Total
Residence.....	10	18	5	1	4	3	...	1	1	103	23	4	173
Cab & carriage.	2	6	1	3	2	2	...	...	2	33	13	...	64
Parents & others	...	...	...	...	...	...	...	25	...	2	2	11	40
Street.....	6	18	13	6	2	...	...	...	9	55	18	1	128
Walked.....	29	70	9	12	12	2	...	...	17	236	294	5	686
Police.....	...	10	1	1	...	...	...	23	30	120	5	...	190
City Prison....	2	...	2	...	...	...	...	...	10	21	1	...	36
Totals.....	49	122	31	23	20	7	0	49	69	570	356	21	1,317

CASES ORIGINATING IN OTHER HOSPITALS

Flower.....	4	14	4	9	1	...	...	1	2	18	16	...	69
New York.....	8	13	7	4	2	...	1	...	4	8	15	1	63
House of Relief.	7	16	15	5	2	...	...	...	4	1	15	1	66
St. Vincent's...	5	17	5	6	...	...	...	...	8	13	13	...	67
Presbyterian...	...	5	4	1	1	1	...	1	...	10	...	...	23
Gouverneur....	...	7	1	5	...	1	...	...	1	19	13	...	47
All others.....	4	10	2	1	4	1	...	1	...	41	7	...	71
Totals.....	28	82	38	31	10	3	1	3	19	110	79	2	406
	77	204	69	54	30	10	1	52	88	680	435	23	1,723

TABLE V.

Bellevue Hospital.

Length of Stay in Bellevue Hospital by Character of Disease of the Patients Transferred to Other Institutions During the Three Months Ended December 31, 1911.

	0 day		1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent
Acute Medical	9	11.8	1	1.3	11	14.2	22	28.6	31	44.1	74	100
Chronic Medical	14	6.9	5	2.5	52	25.0	56	25.3	80	40.3	207	100
Fractures	9	13.0	...	....	11	16.0	17	24.7	32	46.3	69	100
Other Surgical	14	25.9	..	....	15	27.8	11	20.4	14	25.9	54	100
Genito-urinary	7	23.4	1	3.3	7	23.3	8	26.7	7	23.3	30	100
Gynecological	1	10.0	...	....	1	10.0	3	30.0	5	50.0	10	100
Obstetrical	1	100.0	...	....	...	....	...	....	...	....	1	100
Children	4	7.7	6	11.5	13	25.0	5	9.6	24	46.2	52	100
Alcoholic	1	1.2	3	3.4	32	36.3	34	38.6	18	21.5	88	100
Insane	1	.2	14	2.1	432	63.5	167	24.5	66	9.7	680	100
Tuberculosis	3	.7	...	....	285	65.5	88	20.2	59	13.6	435	100
Contagious	9	39.2	4	17.3	4	17.3	3	13.1	3	13.1	23	100
Totals	73	4.3	34	1.9	863	50.1	414	23.7	339	20.0	1,723	100

TABLE VI.

Bellevue Hospital.

Length of Stay in Bellevue Hospital by Disposition of Patients Transferred to Other Hospitals During the Three Months Ended December 31, 1911.

	0 day		1 day		2—4 days		5—9 days		10+days		
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total
Medical and Surgical:											
Metropolitan Hospital, City Hospital, City Home, Manhattan	55	11.5	9	1.8	115	23.6	128	25.9	180	37.2	487
Miscellaneous	14	11.6	11	9.1	30	24.8	27	22.3	39	32.2	121
Totals	69	11.5	20	3.3	145	24.0	155	25.0	219	36.2	608
Insane:											
State Hospitals	1	.1	14	2.1	432	63.5	167	24.6	66	9.7	680
Tuberculosis:											
Metropolitan Hospital	2		...		235		78		45		360
St. Joseph's Hospital	1		...		29		5		7		42
St. Vincent's Hosp., S. I.	...		...		12		...		...		12
Riverside Hospital	...		...		9		5		7		21
Totals	3	.7	...	...	285	65.5	88	20.2	59	13.6	435
Total											1,723

Of the 121 patients classed as "Miscellaneous" 23 were contagious cases; 52 were children; and 46 alcoholic. The contagious were all transferred to Reception Hospital; the children to New York Foundling, New York Infant, Misericordia, and Randall's Island; and the alcoholics to the workhouse.

TABLE VII.

BELLEVUE HOSPITAL.

PATIENTS TRANSFERRED FROM BELLEVUE HOSPITAL TO METROPOLITAN HOSPITAL, CITY HOSPITAL, AND CITY HOME DURING THE THREE MONTHS ENDED DECEMBER 31, 1911.

This table shows the kinds of disease and lengths of stay in Bellevue Hospital of these patients.

(Tuberculosis not included)

	Metropolitan Hospital						City Hospital					
	0 day	1 day	2–4 days	5–9 days	10+ days	Total	0 day	1 day	2–4 days	5–9 days	10+ days	Total
Acute Medical	5	...	5	8	11	29	3	1	3	15	20	42
Chronic Medical	7	...	12	17	18	54	3	3	23	26	52	107
Fractures	3	...	4	4	11	22	4	...	5	7	17	33
Other Surgical	12	...	6	5	6	29	2	...	8	5	7	22
Genito-urinary	1	...	3	2	2	8	6	1	4	4	5	20
Gynecological	..	...	...	...	3	3	1	...	1	2	1	5
Obstetrical	..	...	...	...	...	...	1	...	...	...	...	1
Children	..	...	...	...	2	2	...	...	1	...	2	3
Alcoholic	1	...	7	6	3	17	...	...	11	8	7	26
Totals	29	...	37	42	56	164	20	5	56	67	111	259

	City Home						Totals for These Three Institutions					
Acute Medical	1	...	...	...	...	1	9	1	8	23	31	72
Chronic Medical	4	2	17	13	10	46	14	5	52	56	80	207
Fractures	1	...	2	2	1	6	8	...	11	13	29	61
Other Surgical	1	...	1	...	...	2	15	...	15	10	13	53
Genito-urinary	..	...	1	...	1	2	7	1	8	6	8	30
Gynecological	..	...	...	1	1	2	1	...	1	3	5	10
Obstetrical	..	...	...	...	...	...	1	...	...	...	...	1
Children	..	...	...	...	...	...	...	...	1	...	4	5
Alcoholic	..	2	1	1	1	5	1	2	19	15	11	48
Totals	7	4	22	17	14	64	56	9	115	126	181	487

TABLE VIII.

Kings County Hospital.

Number and Classification of Patients Transferred to Kings County Hospital from Other Hospitals During the Three Months Ended December 31, 1911.

This table groups the patients according to their diseases at the time of transfer to Kings County Hospital and upon the final disposition of their cases.

	Medical		Surgical										
	Acute	Chronic	Fractures	Other Cases	Genito-urinary	Gynecological	Obstetrical	Children	Alcoholic	Insane	Tuberculosis	To Home through Kings County Hosp.	Total
Received from:													
Bradford Street Hospital..	7	3	7	12	1	..	4	2	5	..	1	..	42
Brooklyn Hospital.....	..	1	..	..	..	..	..	..	6	..	1	..	8
Bushwick Hospital.....	..	1	1	2	..	..	..	..	3	1	..	..	8
Coney Island Hospital.....	1	4	..	1	1	..	..	1	2	..	2	..	12
Cumberland Street Hospital	3	1	2	1	..	..	..	..	4	..	3	..	14
Eastern District Hospital..	1	1	1	..	..	..	..	..	3	1	..	..	7
Flushing Hospital.....	2	..	..	..	..	..	..	..	..	..	..	1	3
German Hospital.....	..	3	..	..	..	..	..	..	3	..	..	..	6
Jamaica Hospital.....	..	1	..	..	..	..	..	..	..	..	..	..	1
L. I. College Hospital.....	1	..	..	..	..	..	1	..	4	..	..	..	6
L. I. State Hospital.....	..	..	..	..	..	..	..	..	..	..	..	..	..
Norwegian Hospital.....	1	2	..	..	..	..	..	..	8	..	1	..	12
St. Catherine's Hospital...	..	1	..	..	..	..	..	..	..	..	3	1	5
St. John's Hospital.....	1	..	1	..	..	..	..	..	5	..	..	1	8
St. Mary's Hospital.....	1	3	..	1	..	1	..	1	..	..	1	..	8
Seney (M. E.) Hospital....	1	5	..	..	..	..	..	..	3	..	..	..	9
Swedish Hospital.....	..	1	..	..	..	1	..	..	5	..	..	..	7
Williamsburgh Hospital....	2	..	1	..	..	..	..	..	10	1	2	..	16
Totals.....	21	27	13	17	2	2	5	4	61	3	14	3	172
Discharged to:													
Residence.....	10	12	10	15	2	1	4	2	40	..	2	..	98
L. I. State Hospital.....	..	..	..	..	..	..	..	..	..	1	..	..	1
L. I. College Hospital.....	..	..	..	..	..	..	..	..	..	..	1	..	1
Metropolitan Hospital.....	..	..	..	..	..	..	..	..	..	..	2	..	2
St. Peter's Hospital.....	..	1	..	..	..	..	..	..	..	..	..	..	1
City Home, Brooklyn.....	1	5	1	..	..	..	..	..	1	..	..	3	11
Kings County Hospital*...	..	1	..	1	..	..	1	..	4	2	..	..	9
Kings County Hospital ("Unpaid Helpers")	..	..	..	..	..	..	..	..	2	..	..	..	2
Died.....	10	8	2	1	..	1	..	2	14	..	9	..	47
Totals.....	21	27	13	17	2	2	5	4	61	3	14	3	172

* Transferred within the Hospital.

TABLE IX.

Kings County Hospital.

Length of Stay by Character of Disease and Disposition of Patients Transferred to Kings County Hospital from Other Hospitals During the Three Months Ended December 31, 1911.

The first section of this table shows the patients according to their classification and the length of their stay in Kings County Hospital, in numbers and percentages; and the second section shows the disposition of the patients according to the length of their stay in Kings County Hospital, in numbers and percentages.

Character of Disease

	1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent.
Acute Medical	1	5.0	6	28.5	4	19.0	10	47.5	21	100
Chronic Medical	1	3.8	6	22.2	8	29.6	12	44.4	27	100
Fractures	1	7.7	1	7.7	..	....	11	84.6	13	100
Other Surgical	..	....	3	17.6	3	17.7	11	64.7	17	100
Genito-urinary	..	....	..	....	..	....	2	100.0	2	100
Gynecological	..	....	..	....	1	50.0	1	50.0	2	100
Obstetrical	..	....	1	20.0	1	20.0	3	60.0	5	100
Children	..	....	..	....	2	50.0	2	50.0	4	100
Alcoholic	4	6.6	42	68.8	11	18.0	4	6.6	61	100
Insane	..	....	2	66.7	..	....	1	33.3	3	100
Tuberculosis	..	....	2	14.3	3	21.4	9	64.3	14	100
No diagnosis	2	66.7	1	33.3	..	....	..	....	3	100
Totals	9	5.2	64	37.2	33	19.2	66	38.4	172	100

Disposition

	1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent.
Residence	3	3.0	36	36.7	15	15.3	44	44.9	98	100
City Home, B'klyn	2	18.2	5	45.4	1	9.1	3	27.3	11	100
Kings County Hosp.	..	....	3	33.3	1	11.1	5	55.6	9	100
All others	..	....	3	43.0	1	14.0	3	43.0	7	100
Died	4	8.5	16	34.1	15	31.9	12	25.5	47	100
Totals	9	5.3	63	37.2	33	19.2	67	38.3	172	100

TABLE X.

Kings County Hospital.

Number and Classification of Patients Transferred from Kings County Hospital During the Three Months Ended December 31, 1911.

	Medical		Surgical									
	Acute	Chronic	Fractures	Other Cases	Gynecological	Obstetrical	Children	Alcoholic	Insane	Tuberculosis	"Non Curata"	Total
Transferred to:												
B'klyn Home for Consumptives	..	..	..	..	..	..	..	..	..	1	..	1
Angel Guardian Home	..	..	..	..	..	..	5	..	..	..	..	5
Central Islip State Hospital	..	..	..	..	..	..	..	..	25	..	..	25
City Home, Brooklyn	12	91	3	10	..	..	..	26	..	..	51	193
Combes Sanitarium	..	..	..	..	..	..	..	..	1	..	..	1
Farm Colony	..	1	..	..	..	..	..	..	..	..	..	1
Hudson River State Hospital	..	..	..	..	..	..	..	..	1	..	..	1
Kings Park State Hospital	..	..	..	..	..	..	..	..	180	..	..	180
Long Island State Hospital	..	..	..	1	1	..	..	..	76	..	..	78
Metropolitan Hospital	..	3	..	..	..	..	..	..	..	54	..	57
New York Foundling Hospital	..	..	..	..	..	1	1	..	..	..	..	2
Queens County Jail	..	..	..	..	..	..	..	..	1	..	..	1
Randall's Island	..	..	..	..	..	..	..	..	5	..	..	5
St. Mary's Hospital	1	..	..	..	..	..	..	..	..	..	..	1
St. Joseph's Hospital	..	..	..	..	..	..	..	..	..	1	..	1
St. Joseph's Home, Flushing	..	..	..	..	..	..	1	..	..	..	..	1
St. Peter's Hospital	..	1	..	..	..	..	..	..	..	2	..	3
St. Rose's Cancer Home, Mhtn.	..	..	..	2	1	..	..	..	..	..	..	3
Seney Hospital	..	..	1	..	1	..	..	..	..	1	..	3
Totals	13	96	4	13	3	1	7	26	289	59	51	562

TABLE XI.

KINGS COUNTY HOSPITAL.

LENGTH OF STAY IN KINGS COUNTY HOSPITAL BY DISPOSITION AND CHARACTER OF DISEASE OF PATIENTS TRANSFERRED TO OTHER HOSPITALS DURING THE THREE MONTHS ENDED DECEMBER 31, 1911.

	1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent.
State Hospitals, Insane	39	13.5	97	33.6	44	15.2	109	37.7	289	100
Metrop'tan Hosp., Tbc.	..	....	12	20.4	17	28.8	30	50.8	59	100
City Home, B'klyn...	58	30.0	58	30.0	32	16.7	45	23.3	193	100
Miscellaneous.....	3	14.3	2	9.5	1	4.8	15	71.4	21	100
Totals.....	100	18.0	169	30.0	94	16.7	199	35.3	562	100

CLASSIFICATION OF ONE HUNDRED AND NINETY-THREE CASES TRANSFERRED TO CITY HOME, BROOKLYN.

	1 day		2—4 days		5—9 days		10+days			
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Total	Per Cent.
Medical.....	12	11.7	30	29.1	28	27.2	33	32.0	103	100
Surgical.....	..	....	4	30.8	..	....	9	69.2	13	100
Alcoholic.....	2	7.8	22	84.6	1	3.8	1	3.8	26	100
"Non Curata".....	44	86.3	2	3.9	3	5.9	2	3.9	51	100
Totals.....	58	30.0	58	30.0	32	16.5	45	23.5	193	100

5. THE MORGUE SERVICE

THE INVESTIGATION

The morgue service throughout the City of New York is conducted by the Commissioner of Public Charities.

The morgue building is located on the grounds of Bellevue Hospital. Although located on the Bellevue grounds, it is still under the management and control of the Commissioner of Charities, for when Bellevue and its allied hospitals were separated from the Department of Public Charities in 1902 the separation did not carry with it the management of the morgue adjoining Bellevue. It has been, and still is, necessary to transfer all dead bodies from Bellevue Hospital to the morgue under the control of the Commissioner of Charities.

This morgue received 11,697 bodies during the year 1911. This number included bodies from the correctional institutions, and also 515 from Manhattan State Hospital. Of the total number received, 5,509 were claimed and buried by friends, 5,456 were buried by the City, and 732 were transferred to institutions for anatomical purposes.

The building used as a morgue has for a number of years been inadequate to handle the large number of bodies received and discharged from it. Owing to this fact, when the pathological building at Bellevue was planned it was deemed wise to incorporate in it an adequate morgue. Accordingly, space was set aside for this purpose, and it was subsequently completely equipped. This new morgue has coolers with a capacity for 225 bodies; a general autopsy room containing six slabs; one private autopsy room; two autopsy rooms for the use of coroners' physicians; an undertaker's class room, with 4 operating tables; and an undertaker's embalming room, with 4 tables. There is also an exhibition room containing 24 cases for the display of unknown dead, and there is a chapel wherein obsequies may be held. The provisions are probably more ample than will be needed for many years to come, and yet it was probably wise in planning the morgue to provide space for the growing needs of the City.

Inasmuch as the Bellevue authorities apparently have not power to operate a general morgue, this morgue on completion was offered to the Commissioner of Charities for operation. The Commissioner of Charities in reply to this offer on January 26, 1912, addressed a communication to the Board of Trustees of Bellevue Hospital, asking what portion of the building was tendered for his use; whether the Trustees would heat and light the building and furnish refrigeration; and what would be the extent of his jurisdiction. The Trustees replied on January 30th, stating that the space allotted to the morgue would be under the complete jurisdiction of the Commissioner, and that the Trustees would heat, light, and refrigerate the morgue. On March 28th the Commissioner replied to the Trustees that he would operate the morgue "* * * * provided the title of the said building is vested in the Department of Public Charities * * *" Inasmuch as but a small portion of the building is occupied by the morgue, and the remainder of the building is devoted to laboratories and dormitories used by Bellevue, the Trustees could not see their way clear to transfer the jurisdiction of the whole building to the Commissioner. The Commissioner subsequently concluded that he would operate the morgue without the transfer of the title of the whole building, but no action was taken on his part to secure appropriations for such operation until the summer of 1913.

Thus this valuable morgue property has remained unused since completion for a period of more than two years.

The new morgue being much larger and more elaborate than the old morgue would necessarily require considerably more employees to operate it. The Commissioner in June, 1913, submitted to the Secretary of the Borough of Manhattan a tentative list of helpers who in his opinion would be needed to properly operate the morgue. The aggregate salaries suggested for this list of employees amounted to $21,060. The cost of service in the old morgue is approximately $3,300 per year.

It seems highly advisable that the new morgue should be opened as soon as possible in order that its splendid facilities may be put into use. These enlarged facilities will necessarily cost materially more to care for than the limited space and inadequate equipment of the old morgue. It seems unnecessary and inadvisable, however, to provide the number of employees and the aggregate amount of salary suggested by the Commissioner. After a careful survey of the morgue and the functions to be performed it is recommended that there be appropriated for this purpose the sum of $12,480, to be distributed as indicated in the following table, which also sets forth the request made by the Commissioner:

ESTIMATE OF THE NUMBER OF EMPLOYEES NEEDED TO OPERATE THE NEW MORGUE AND WAGES FOR SAME.

Functions	Estimate of Department of Public Charities			Estimate of Committee		
	Number	Salary	Total	Number	Salary	Total
Morgue Keeper	1	$1,050	$1,050	1	$1,080	$1,080
Assistant Morgue Keeper (Day)	1	600	600	1	600	600
Assistant Morgue Keeper (Night)	1	600	600	1	600	600
Clerk	1	1,050	1,050	1	720	720
Hearse Service, Driver (Day)	1	720	720	1	600	600
Hearse Service, Helper (Day)	1	600	600	1	480	480
Hearse Service, Driver (Night)	1	720	720	1	600	600
Hearse Service, Helper (Night)	1	600	600	1	480	480
Boat and Dock Service (Day)	4	600	2,400	1	600	600
				1	480	480
Boat and Dock Service (Night)	2	600	1,200	2	480	960
Elevator Attendant, Basement to Ground Floor (Day)	1	600	600	1	480	480
Elevator Attendant Basement to Ground Floor (Night)	1	600	600	1	480	480
Elevator Attendant to Chapel and to 29th Street Entrance	1	600	600	1	480	480
Guide to Visitors (Day)	1	720	720	..	...	...
To Handle Bodies on Ground Floor (Day)	3	600	1,800	2	600	1,200
				1	360	360
To Handle Bodies on Ground Floor (Night)	2	600	1,200	2	480	960
To Handle Bodies 1st Floor (Day)	2	600	1,200			
To Handle Bodies 1st Floor (Night)	1	600	600			
	1	480	480			
To Handle Bodies 2d Floor (Day)	2	600	1,200	2	480	960
To Handle Bodies 2d Floor (Night)	1	600	600			
	1	480	480			
Cleaners	3	480	1,440	1	360	360
Totals	34		$21,060	23		$12,480

RATIO OF NURSES TO PATIENTS PROPOSED FOR MUNICIPAL HOSPITALS

THE INVESTIGATION

When this investigation was begun it was intended to make an examination of the nursing situation generally. Such an inquiry would have involved a study of the courses now given in nursing schools and their adequacy and scope; the practical work required of the pupil nurse; the time devoted to such work, both as to term and hours per day; the degree to which the graduate nurse is filling the demands for nursing service; the relation of the physician to the nurse; and other phases of the subject. Considerable effort was put forth in an endeavor to find an investigator competent and free to undertake this phase of the work, but no such person could be found within the limit of time in which the investigation could be undertaken.

The investigation of the hospitals has emphasized the necessity for an investigation covering the above phases of the nursing problem. The relations between the hospital and the nurse, the public and the nurse, the physician and the nurse, are in many regards unsatisfactory. Nursing associations are endeavoring to improve conditions, and to meet the demand for nursing by educating a sufficient supply of well trained, competent nurses. The supply, however, is by no means adequate to the needs, and it is an open question whether or not some form of training should be offered which would attract and equip a larger number of women for the nursing field; a form of training that would not encroach upon the field of the highly trained nurse.

It was found in this investigation that the ratio of nurses employed in the different municipal hospitals of the City varied greatly. Metropolitan Hospital, General Service, with about 700 beds and 8 admissions yearly per bed, employed 1 trained nurse for each 24 beds. City Hospital, with about 800 beds and 8 admissions yearly per bed, employed 1 trained nurse for each 42 beds. Kings County Hospital, with about 900 beds and 14 admissions yearly per bed, employed 1 trained nurse for each 21 beds. Bellevue Hospital, exclusive of special services, with about 950 beds and about 24 admissions yearly per bed, employed 1 trained nurse for each 16 beds.

No recognized standard of the number of nurses that should be employed to a given number of beds and admissions existed. Each hospital year by year endeavored to secure from the City an increased number of nurses, irrespective of the number employed by any other of the City hospitals. This situation resulted in more or less rivalry between the hospitals, each endeavoring to secure an enlargement of its nursing force by exercising such influence as it might upon the appropriating officers of the City. Under these conditions, it seemed desirable and advisable to establish a ratio of nurses to the number of beds and the number of admissions per year.

A tentative schedule was drawn up and presented to a number of the leading nursing educators in the country, and the conclusions finally reached are set forth in a table which follows. This table divides nurses into three classes: Supervising Nurses; Head Nurses; Pupil Nurses. The

Supervising Nurses class includes all trained nurses not in charge of wards. It includes those in charge of the schools for nursing; instructors; those at the head of the operating room; those in charge of nurses' homes; and those supervising the work of head nurses. It is a class which is designed to include all nurses in the hospital receiving pay higher than that received by head nurses. The Head Nurses class includes those in charge of wards, and such other nurses as may be doing clerical or relief work but receiving approximately the same pay as head nurses. The Pupil Nurses class includes only those receiving instruction.

The ratios given in the table do not assume to provide entirely satisfactory or adequate service, nor do they provide as large a number of nurses as are provided in many of the best private hospitals. The finances of New York City at the present time, however, are not such as to warrant an attempt to provide nursing on the scale provided in these private hospitals. The ratios provided in the table, though not as large as they should be, nevertheless are considerably larger than at present exist in the municipal hospitals, and are large enough to provide a reasonably satisfactory service. *The table is not intended to provide nurses for special services, such as tuberculosis, alcoholic, psychopathic, out-patient, and social service.*

The table is designed to provide ratios which may be adapted to hospitals having a like number of beds but varying in the degree of acute service. As applied to a hospital of each specified size, the first ratio given is on the basis of 10 admissions per year per bed, which in most cases would indicate a hospital partly chronic and partly acute. Provision is made for hospitals having more acute service. The degree of acuteness of service is measured by the number of admissions per bed per year. The general basis on which the schedule is constructed is as follows:

Supervising Nurses in Wards.....1 to each hospital;
1 additional to each 400 beds.
Supervising Nurses in Operating Rooms.....1 to each hospital;
1 additional to each increase of 15,000 admissions yearly.
Head Nurses (day) .....1 to each 30 beds;
1 additional to each increase of 3,000 admissions yearly.
Head Nurses (night).....1 to each hospital;
1 additional to each 400 beds.
Pupil Nurses (day) .....1 to each 10 beds;
1 additional to each increase of 500 admissions yearly.
Pupil Nurses (night).....1 to each 30 beds;
1 additional to each increase of 3,000 admissions yearly.

Provision is also made for the supervision of the nursing school and home. The number of relief and clerical nurses necessary would depend on local conditions. In the present schedule the assignment of these is arbitrary.

To illustrate by the schedule: A hospital having 900 beds, with 9,000 yearly admissions, would require a superintendent of the nursing school; 2 instructors; 1 supervisor of the nurses' home; 1 supervising nurse for the operating room; 3 supervising nurses in the wards (total of 8 supervising nurses); 30 head nurses for day work; 3 head nurses for night work; 3 relief nurses; 2 head nurses for operating room; 1 head nurse for clerical work (total of 39 head or trained nurses); 90 pupil nurses for day work; 30 pupil nurses for night work (total of 120 pupil nurses), making a complete total of 167 nurses. If the same hospital should increase to 18,000 admissions yearly, it would then require an increase of 1 supervising

nurse in the operating rooms (making a total of 9 supervising nurses); an increase of 3 head nurses for day work and an increase of 1 head nurse for the operating room (making a total of 43 head or trained nurses); an increase of 18 pupil nurses for day work and an increase of 3 pupil nurses for night work (making a total of 141 pupil nurses), so that the complete total number of nurses would then be 193.

Should the hospitals find it impossible to secure the number of pupil nurses provided for in the appropriation, it would seem advisable to permit the hospitals to use the unexpended balance of such appropriation for head nurses and attendants. A satisfactory ratio for such substitution would be 1 head nurse and 3 attendants for each 10 pupil nurses lacking. The aggregate salary of the 10 pupil nurses would average about $1,500; the wages of those substituted would be the same—1 head nurse, $600; 3 attendants at $360 each.

The suggested basis will be found on the following page.

Basis for Estimating the Number of Nurses Required in Municipal Hospitals Varying in Size and in Proportion of Acute and Chronic Cases Treated.

	Supervising Nurses						Head Nurses							Pupil Nurses				
Bed Capacity	Superintendent School for Nurses	Instruction	In Charge of Home	Operating Room	On Wards	Total	Day	Night	Relief	Operating Room	Clerical	Total	Total Trained Nurses	Day	Night	Total	Total Nurses	Yearly Admissions
200	1	..	1	1	1	4	7	1	1	1	1	11	15	20	7	27	42	2,000
	1	..	1	1	1	4	7	1	1	1	1	11	15	22	7	29	44	3,000
	1	..	1	1	1	4	7	1	1	1	1	11	15	24	7	31	46	4,000
	1	..	1	1	1	4	7	1	1	1	1	11	15	26	7	33	48	5,000
300	1	..	1	1	1	4	10	1	1	1	1	14	18	30	10	40	58	3,000
	1	..	1	1	1	4	10	1	1	1	1	14	18	32	10	42	60	4,000
	1	..	1	1	1	4	10	1	1	1	1	14	18	34	10	44	62	5,000
	1	..	1	1	1	4	11	1	1	1	1	15	19	36	11	46	65	6,000
400	1	..	1	1	1	4	13	1	1	1	1	17	21	40	13	53	74	4,000
	1	..	1	1	1	4	13	1	1	1	1	17	21	42	13	55	76	5,000
	1	..	1	1	1	4	13	1	1	1	1	17	21	44	13	57	78	6,000
	1	..	1	1	1	4	14	1	1	1	1	18	22	46	14	60	82	7,000
500	1	1	1	1	2	6	17	2	1	1	1	22	28	50	17	67	95	5,000
	1	1	1	1	2	6	17	2	1	1	1	22	28	52	17	69	97	6,000
	1	1	1	1	2	6	17	2	1	1	1	22	28	54	17	71	99	7,000
	1	1	1	1	2	6	18	2	1	1	1	23	29	56	18	74	103	8,000
600	1	1	1	1	2	6	20	2	2	2	1	27	33	60	20	80	113	6,000
	1	1	1	1	2	6	20	2	2	2	1	27	33	64	20	84	117	8,000
	1	1	1	1	2	6	21	2	2	2	1	28	34	68	21	89	123	10,000
	1	1	1	1	2	6	22	2	2	2	1	29	35	72	22	94	129	12,000
700	1	1	1	1	2	6	23	2	2	2	1	30	36	70	23	93	129	7,000
	1	1	1	1	2	6	23	2	2	2	1	30	36	74	23	97	133	9,000
	1	1	1	1	2	6	24	2	2	2	1	31	37	78	24	102	139	11,000
	1	1	1	1	2	6	25	2	2	2	1	32	38	82	25	107	145	13,000
800	1	2	1	1	3	8	27	3	2	2	1	35	43	80	27	107	150	8,000
	1	2	1	1	3	8	27	3	2	2	1	35	43	84	27	111	154	10,000
	1	2	1	1	3	8	28	3	2	2	1	36	44	88	28	116	160	12,000
	1	2	1	1	3	8	29	3	2	3	1	38	46	92	29	121	167	14,000
900	1	2	1	1	3	8	30	3	3	2	1	39	47	90	30	120	167	9,000
	1	2	1	1	3	8	31	3	3	3	1	41	49	96	31	127	176	12,000
	1	2	1	2	3	9	32	3	3	3	1	42	51	102	32	134	185	15,000
	1	2	1	2	3	9	33	3	3	3	1	43	52	108	33	141	193	18,000
1000	1	2	1	1	3	8	33	3	3	2	1	42	50	100	33	133	183	10,000
	1	2	1	1	3	8	34	3	3	3	1	44	52	106	34	140	192	13,000
	1	2	1	2	3	9	35	3	3	3	1	45	54	112	35	147	201	16,000
	1	2	1	2	3	9	36	3	3	3	1	46	55	118	36	154	209	19,000
1100	1	2	1	1	3	8	37	3	3	2	1	46	54	110	37	147	201	11,000
	1	2	1	1	3	8	38	3	3	3	1	48	56	116	38	154	210	14,000
	1	2	1	2	3	9	39	3	3	3	1	49	58	122	39	161	219	17,000
	1	2	1	2	3	9	40	3	3	3	1	50	59	128	40	168	227	20,000
1200	1	3	1	1	4	10	40	4	4	3	2	53	63	120	40	160	223	12,000
	1	3	1	1	4	10	41	4	4	3	2	54	64	126	41	167	231	15,000
	1	3	1	2	4	11	42	4	4	3	2	55	66	132	42	174	240	18,000
	1	3	1	2	4	11	43	4	4	3	2	56	67	138	43	181	248	21,000
	1	3	1	2	4	11	44	4	4	3	2	57	68	144	44	188	256	24,000
	1	3	1	2	4	11	45	4	4	3	2	58	69	150	45	195	264	27,000
	1	3	1	3	4	12	46	4	4	4	2	60	72	156	46	202	274	30,000
	1	3	1	3	4	12	47	4	4	4	2	61	73	162	47	209	282	33,000
	1	3	1	3	4	12	48	4	4	4	2	62	74	168	48	216	290	36,000

CHILDREN'S SERVICES

IN THE

MUNICIPAL HOSPITALS IN MANHATTAN AND THE BRONX

THE INVESTIGATION

Nothing usually arouses more concern in a family than the illness of a child. It is well known that such an illness, however slight, may have fatal results. Children lack endurance, and die apparently from slight causes. About one-half of the mortality is among those under fifteen years of age, and one-third of the mortality is in the first and second years of life. The largest mortality is where there is the most sickness, for the sickness of children is chiefly acute. The reduction of this high mortality and the restoration of the children to health is attended by difficulties, and their treatment requires special methods and facilities.

The premature child, for instance, requires a higher degree of heat than the normal; also, special feeding and constant attention. Among our eight municipal hospitals, Bellevue only has a room where the temperature can be forced to the 95 degrees required for the premature child. Only four of the hospitals have attending children's specialists, and the ratio of nurses to children in the main ward, except in Bellevue, is as follows: Harlem 3 to 26; Gouverneur 3 to 30; Fordham 5 to 62 (same nurses covering both main and detention wards); Metropolitan 3 to 26; City 3 to 16; etc. The standard set by The Babies' Hospital is one nurse to 3 children.

The great number of feeding cases to be cared for shows the importance of special knowledge and facilities for feeding. In fact, the treatment of all children's diseases is successful only where nutrition is skilfully adjusted, and this is one of the main reasons why all children in a general hospital should be attended by a children's specialist who is thoroughly versed in such matters.

Children seem especially subject to pneumonia, and this disease ranks first in all the lists of children's medical cases admitted during 1911. It is generally recognized that abundance of fresh outdoor air is an effective treatment, but in most of the hospitals, those children admitted who are in the acute stages of the disease are kept for at least 48 hours in detention rooms, which are invariably inferior to the main ward, and in these rooms they frequently suffer from insufficient air. The pneumonia cases are often ultimately placed on the ward veranda, at least by day, but these verandas, except at Bellevue, are everywhere poorly protected.

Children are much more subject to contagion and infection than adults. Epidemics spread among them with great rapidity. During its stay in a single detention room or general children's ward a child may, and frequently does, contract other diseases than that with which it entered. Provisions for sufficient detention and isolation rooms, the enforcement of precautions against the spreading of disease by doctors and nurses, and the securing of suitable environment for the children in the main wards to which they are ultimately assigned, have not been thoroughly carried out in any public hospital in New York City.

A well equipped and well administered children's service must always contend with the dangers of loss of weight and appetite due to restlessness

and worry in the new environment, and it must be remembered that a child needs entertainment and amusement, as well as treatment.

The restless little convalescents should also be grouped away from very sick and dying children. That the special provision needed is now made in but a very limited degree is indicated by the table on page 23, which shows the number of beds provided in the main children's wards; the number of children counted in such wards on certain days; and the census shown by the hospital on these same days.

The table indicates that the beds provided for children in most of our hospitals are frequently overcrowded. For instance, in Ward 15 of Bellevue, having a capacity of 15 beds, on 3 days, at different periods, there were 17, 15, and 18 children, respectively. The main ward for children in Harlem Hospital has a capacity of 26 beds. In the whole Hospital, on different days, there were 31 and 26 children, respectively. The Hospital census shows that there were 17 children in the main children's ward during each of the 2 days. This indicates that on the first day there were 14 children in the Hospital in other wards than the main ward assigned to children, and on the second day there were 9 children distributed in the various wards. The main ward for children in Fordham has a capacity of 42. On 3 successive days there were in the whole Hospital 39, 50, and 36 children, respectively. The hospital census for these days shows that there were 21, 23, and 23 children, respectively, in the children's ward. Thus, on the first day there were 18 children distributed in the various wards; on the second day there were 27; and on the third day there were 13. The children's ward in City Hospital has a capacity of 16 beds. During a period of 3 days the Hospital contained 71, 72, and 65 children, respectively. The Hospital census showed that there were 11, 13, and 15 children, respectively, in the main children's ward. Thus, it will be noted that on the first day 60 children were distributed in various wards other than the children's ward; on the second day 59; and on the third day 50. Since the above observations were made conditions have been materially bettered in City Hospital.

One ward for children affords inadequate facilities for classification and gives more excuse for distributing children through adult wards, but children in adult wards receive insufficient and inexperienced care. It is scarcely open to argument that the children in a hospital should be cared for only by those experienced in children's ailments, both physicians and nurses.

Children's Cases in Some of the Municipal Hospitals in New York City During the Year 1911

On subsequent pages tables will be found setting forth the classes and numbers of cases cared for during 1911 by Bellevue, Fordham, Gouverneur, Harlem, Metropolitan, and City Hospitals. The first three tables give in detail the number of cases, and total and average length of stay according to ailments. The cases showing complications are also set forth. The last table gives a summary of the preceding tables, and indicates more briefly the total number of surgical, medical, and infectious cases handled. The information contained in the tables was taken from the case records at each hospital.

An examination of the summary table readily shows the difference in the character of cases handled by these institutions. It will be noticed

that Gouverneur and Harlem Hospitals handled within 1 of the same number of cases during the year. Gouverneur cared for 561 surgical cases, as compared with 416 in Harlem; whereas, of medical cases, Gouverneur handled 663, as compared with 798 in Harlem. Harlem Hospital seemed to run much heavier to medical cases, and to have a much lighter service in surgical cases. In contrast to these two Hospitals it will be noticed that Fordham cared for 794 surgical cases and 587 medical cases. In contrasting Gouverneur with Bellevue Hospital, both being in downtown sections of the City, it will be seen that about 45 per cent. of the cases handled by Gouverneur were surgical, whereas, but 27 per cent. of those cared for in Bellevue were surgical cases. The proportion of surgical cases in Metropolitan Hospital was 23 per cent.; in City Hospital 26 per cent.; and in Fordham Hospital 56 per cent.

In reviewing the average periods of stay attention is given only to the cases without complications, as it would be impracticable to base an average upon conditions of an unrepresentative character. For a similar reason the cases in the two principal services were grouped in three classes: emergency, acute, and long-term.

The emergency surgical cases remained somewhat longer at the hospitals of Bellevue Department than at Bellevue itself, the average stay in the respective hospitals having been as follows: Bellevue 13 days; Fordham 17 days; Gouverneur 22 days; and Harlem 18 days. On the other hand, acute cases remained longer at Bellevue than at the others, the average length of stay at Bellevue having been 15 days, as compared with 14 days at Fordham; 12 days at Gouverneur; and 11 days at Harlem. So called long term surgical cases remained about the same period in Bellevue, Harlem, and Gouverneur; namely, 35 days in the two former, and 37 days in Gouverneur, whereas in Fordham they were discharged after an average stay of 17 days.

There was a difference of only 2 days in the average period of stay of emergency medical cases in Bellevue and Allied Hospitals; 6 days having been the average at Bellevue and Harlem and 4 days at Fordham and Gouverneur. Comparison of the average lengths of stay of acute cases does not show any greater disparity. At Bellevue and Fordham the average stay was 12 days; at Gouverneur 13 days; and at Harlem 10 days. There was not much difference between the average periods of stay in the long term cases at Bellevue, Fordham, and Gouverneur; namely, 17, 16, and 16 days, respectively, but the average stay of 13 days at Harlem was so markedly shorter as undoubtedly to indicate a greater pressure upon the service at that Hospital.

The average length of stay of acute and long-term medical cases in Metropolitan and City Hospitals is noteworthy as compared with Bellevue. In Metropolitan the acute medical remained an average of 35 days, and those classed as long term 91 days. In City Hospital the acute cases remained on an average of 27 days and the long term cases 49 days. The acute and long term surgical cases showed a similar difference. In Metropolitan the acute class remained an average of 30 days and the long term 51 days. The acute cases remained on an average of 31 days in City Hospital and the long term 44 days. The average stay in these hospitals seems unnecessarily high. The average stay was probably largely increased by quite a number of comparatively well children who were allowed to remain in the hospitals.

The length of stay of infectious cases in the hospitals is of interest. In

Bellevue they remained on an average of 9 days; in Fordham 7 days; in Harlem 9 days; and in Gouverneur 17 days, whereas, in Metropolitan Hospital they remained 57 days, and in City Hospital 54 days. Of the acute surgical cases in Fordham Hospital, 77 per cent. developed complications, as contrasted with 23 per cent. in Bellevue, and 18 per cent. in Gouverneur Hospital.

The number of cases showing complications in the different hospitals should be noticed. Of all the cases treated by Bellevue, 16 per cent. showed complications; in Fordham 32 per cent.; Harlem 4 per cent.; Gouverneur 19 per cent.; and Metropolitan 13 per cent. The records were not kept so as to show complications at City Hospital. Fordham Hospital seems to be exceptionally high in the proportion of complications arising in its services.

It is of interest to observe the proportion of different ailments treated in the different hospitals. Of wounds, sprains, contusions, and fractures, the proportion in Bellevue was 33 per cent. of the total number of surgical cases; in Fordham 15 per cent.; in Gouverneur 31 per cent.; and in Harlem 31 per cent. It might be expected that Gouverneur and Bellevue would show the highest percentage of fractures, whereas Harlem Hospital is slightly higher than either. On the other hand, Fordham should show a much less proportion, and does, according to the percentages.

Bellevue treated 182 cases of broncho-pneumonia, which was 7 per cent. of its total medical cases. In Fordham 6 per cent. of its medical cases were of the same disease; in Gouverneur 21 per cent.; and in Harlem 12 per cent.

Acute gastro-intestinal inflammations in Bellevue constituted 6 per cent. of the total medical cases; in Fordham 4 per cent.; in Gouverneur 16 per cent.; and in Harlem 7 per cent.

Some Aspects of the Children's Service in New York City which Require Attention

There is a definite understanding that the Board of Health shall care for certain contagious diseases, such as scarlet fever, diphtheria, and measles. There is also an understanding that children with eye and skin diseases may either be treated by the Board of Health clinics or go to Randall's Island. It is customary to send whooping-cough cases to Randall's Island or to Metropolitan Hospital, though Metropolitan has only the hospitality of the women's medical ward to offer, and Randall's Island the one or more small, wooden isolation buildings.

Certain classes of cases, such as pulmonary tuberculosis, erysipelas, whooping-cough, vaginitis, mumps, and chickenpox, are on a debatable ground. There is no well defined or adequate provision for them, and if admitted they are scattered throughout the hospital to the imminent danger of other patients. The children's service at Randall's Island is becoming smaller as the custodial asylum there is enlarged, and the other hospitals under the Department of Public Charities are correspondingly burdened with cases of vaginitis, eye, and skin diseases.

The disposition of acute surgical or medical cases which develop a contagious disease is an extremely difficult problem to handle. Removal of a child may endanger its life; nevertheless, few hospitals have isolation rooms where a child having, for example, pneumonia and whooping-cough may, with safety to itself and its neighbors, recover from so dangerous an illness.

The varied nature of the service as set forth in the accompanying tables indicates that a proper classification would require quite a number of distinct and separate rooms. The single detention room and single main ward which are to be found at Harlem, Fordham, and Gouverneur do not permit of any real classification, and Metropolitan and City Hospitals have no detention rooms which can be called such.

Detention Rooms

Each child on entering a hospital is kept, when possible, for observation in the detention room for at least 48 hours. Most children's specialists do not believe that this period is long enough. But the inadequacy of the present detention rooms makes it preferable to hurry the child to the main ward, even though it may be dangerous to the other children in that ward.

An inspection at Harlem Hospital showed that the detention room contained 4 cribs, making an allowance of 273 cubic feet of air per child; but the room frequently holds 5 cribs. It is lighted by a ground glass window, and its single door opens on a corridor where men and women are received from ambulances; doctors and nurses are constantly passing; and the uproar of alcoholic patients is heard. In this room all children with tuberculosis, pneumonia, erysipelas, or appendicitis must remain during hours of suffering from disease and homesickness.

In Gouverneur Hospital the single isolation room opens upon the same corridor as the detention room, and at a distance of only a few steps.

On one visit to this hospital the investigator saw a little girl in the isolation ward tied in her cot. When she attempted to unfasten the knots the nurse said, "Mamie, you're a naughty little girl to run down the hall." In explanation of this remark the nurse said, "Oh, she has chickenpox, and would run among the other patients." Within a few feet of this child, across the narrow hallway, was a cot containing a child with pneumonia and whooping-cough. The latter case had been in the hospital 10 days, and all children going to the main detention ward had to pass between these two contagious cases, and all the cases were attended by the same nurse.

City Hospital devotes one corner of a women's medical ward to detention cases, and at Fordham the detention ward is mainly reached by going through the main ward.

Main Children's Wards

The diagnoses of the children who laid in their cots or played about the floor or verandas in the main wards of the hospitals investigated have been noted. In Harlem Hospital, on April 9, 1912, children in the main ward had the following ailments: fractured femur; mastoiditis; tuberculosis of knee; abscess of neck; empyema; appendicitis; traumatic amputation; fractured skull; fractured leg; pneumonia; pulmonary tuberculosis; paralysis of lower limbs; marasmus; endocarditis; inflammation of middle ear; ruptured appendix; and, in addition, six normal children, whose mothers were patients, were in and about the ward.

In City Hospital, on October 8, 1912, the list was as follows: rickets; pneumonia; impetigo; marasmus; prolapse of rectum; diphtheria (convalescent); fracture of ulna; eye disease (trachoma); ear (running); pediculosis; superficial infection of leg; eye case (not diagnosed); and two normal children, whose mothers were patients, were in and about the ward.

It is evident that the conditions are not conducive to the quickest convalescence of such varied patients. Surgical cases should be grouped by themselves, and not exposed to the epidemics which sweep through the wards. Contagious cases should not be admitted to the hospital, or at any rate to the children's ward. Recourse should not be had to adult wards for the care of inappropriate cases, such as whooping-cough, syphilis, etc. A tubercular or pneumonia case, which needs much cool, fresh air, should be on a veranda, while the marasmic, or premature baby, should not only have abundance of fresh air, but the warmth that it needs. The child recovering from an appendicitis operation should have quiet. The case with pulmonary tuberculosis, the orthopædic case, and the cardiac patient should go to a special hospital or convalescent home, and the idiot should be sent to an asylum. The convalescents should be sent out of the hospital as soon as possible, but, if retained at all, they should at least have a roof ward and a place to play. Certainly no normal children should be admitted to the hospitals, except, perhaps, babies who must be nursed by their mothers, and these should have a place apart.

These self-evident propositions are either utterly disregarded in most of our general public hospitals, or the attempt to enforce them is rendered ineffective by lack of facilities. The little white cots which look so safe and comfortable frequently hold cases which are mutually dangerous.

Separation of Surgical and Medical Cases

Surgical and medical cases lie side by side and are equally exposed to infectious diseases. The following epidemic conditions were noted:

In Gouverneur Hospital, on March 31, 1912, measles appeared. Three children came down with it and were sent away by the Board of Health, and the cases resulted in quarantining the ward, which was the third time it had been quarantined during the winter. At City Hospital cases of scarlet fever and chickenpox were removed from the ward on March 6, 1913, and thereafter 4 children developed chickenpox. On March 9 a child admitted to the ward from the detention room developed diphtheria, putting the ward again in quarantine.

These epidemics greatly reduce the usefulness of the hospitals, since no more children can be admitted to the children's ward until the quarantine is lifted. However, new patients are admitted and placed in the adult wards.

Cross Infection

Children undoubtedly catch many diseases from each other and remain in the hospitals longer than the original diagnoses would warrant. This may be illustrated by the following examples:

Lena Gedhetti was admitted to Metropolitan Hospital on March 18, 1912, aged 1 year and 10 months. She was diagnosed as having whooping-cough and assigned to Ward D. She there contracted measles from contact with some other children who had been sent for the sake of isolation to Ward D from Ward V (girls' and babies' ward). On March 30 she was transferred to Ward V, because there were other cases of measles not fully developed in that ward, and it was considered that one more case would not complicate matters. In Ward V she contracted pneumonia, and also developed an abscess. The child then developed something which resembled erysipelas and was thereupon transferred from Ward V to

Ward X, the female erysipelas isolation ward, where she was exposed to contagion from the other patients. She was finally transferred back to Ward D. During her stay of 7 months and 10 days at Metropolitan Hospital she suffered from whooping-cough, measles, pneumonia, and an abscess.

Convalescents

Children in pain and dying should not be in contact with active little convalescents. In one hospital a lively two-year-old child was seen shaking the cot of another child sick with appendicitis. On April 4, 1912, the investigator noted a little boy in one of the wards who was dying of kidney disease. His face was quite black. The little girl in the next cot was sitting up and watching him with a very distressed expression. It was suggested by the investigator that a screen be placed around the cot, but the nurse said that it was unnecessary, and did not adopt the suggestion.

Happiness helps in the recovery of a child. By the same rule it is bad for children to watch other little patients who are dying or in great pain, as it causes them to have feelings of fear and unreasoning unhappiness that may, in some cases, go so far as to be harmful physically, and most certainly is harmful psychologically.

In the adult wards these influences are very marked. In the winter of 1911 a boy of 13, during his convalescence from pneumonia, sat in a chair by his bed many days between men with delirium tremens. Another boy whose leg was done up in a splint, and who was suffering from a laceration, was detailed by a nurse to help hold in bed a man insane from a blow on the head, and who was offensive in every way. The man was revolting to watch and difficult to handle.

Normal Children

The admission of normal children to the hospitals is an easy way of caring for families and relieving the anxiety of a mother who has been admitted to a hospital. It is, however, indefensible from the point of view of the child, who is exposed to many diseases, and frequently contracts them. The order of the Commissioner of Charities dated June 17, 1912, provided for these children, but it has been only partially carried out. Other children who are entirely normal may also be found in our hospitals, where at times they stop for years. These are children who are without parents, or whose parents have drifted away.

An illustration of such a case was found at City Hospital:

William Collins was admitted December 29, 1910, aged three years. His "residence" was The Catholic Home Bureau, and his primary disease was otitis media. He was recommended for discharge April 29, 1911, but was retained for the reason that his ear was still discharging. On April 1, 1913, the nurse said that the doctors had decided to operate, but no action had been taken, and the child was still at the hospital.

Another case was that of a forlorn child named Frederick Mann, a little colored boy aged four years, whose affliction was diagnosed as syphilis. He was assigned to Ward V in Metropolitan Hospital on January 18, 1910, and was transferred to Willard Parker Hospital on June 3, 1912, infected with scarlet fever. He was readmitted to Metropolitan Hospital on July 25, 1912, and his card read, "No residence, no disease, no friend, no parents." He was at last recommended for discharge in March, 1913.

Only great vigilance on the part of the visiting physicians, superintendents, and social service nurses can prevent such misuse of the wards. Dr. Bacon, Superintendent of City Hospital, while serving as Superintendent of Metropolitan Hospital during March, 1913, discharged 22 children who were normal, but who, for lack of reëxamination, had been permitted to remain in the wards.

Tonsil and Adenoid Cases

Cases have been admitted for operation at all the hospitals studied, but in no instance has any suitable provision been made for them. In one hospital patients waited 12 hours in a diet kitchen without food, and were then given an anæsthetic and operated on in the Dispensary. When such children were kept all night they were placed in the accident ward. In another hospital tonsil and adenoid cases were kept in the observation room with all other cases. The following cases will illustrate this point:

In Gouverneur Hospital, on June 10, 1912, 8 tonsil and adenoid cases were exposed to chickenpox and to vaginitis. (There were 4 cases of chickenpox in the isolation room nearby and 2 vaginitis cases in the hall.) In addition, these cases were exposed to meningitis and bronchitis to the extent of being in the same small room with cases of these ailments. In the same hospital, on June 25, 8 tonsil and adenoid cases in the observation ward were exposed to vaginitis from the isolation room adjoining, and also to contagion from cases of suspected measles, suspected whooping-cough, and acute erysipelas, held in beds in the hall. Cases of pneumonia and meningitis were in the ward with the tonsil and adenoid cases, and all the children were cared for by the same nurse.

Since this inquiry began an effort has been made to limit the number of tonsil and adenoid cases admitted, and to provide beds in a small, separate ward where they can be retained in case of secondary hemorrhage.

Auxiliary Rooms

Auxiliary rooms are needed, especially a recovery room wherein children can be placed until they are well out of ether. There is no such room attached to most of our children's wards, and the moans of their fellow sufferers distress the children very much. A room for dressings should adjoin both medical and surgical divisions. Not infrequently a group of children may be seen holding hands, awaiting their turn with growing terror. Small rooms for observation and quiet should be provided, and a temperature room also is greatly needed. If semi-glass partitions be used additional rooms need not greatly increase the nursing service.

The toilets should be adapted to children, and capable of isolation. This is not the case in any of our hospitals. In City Hospital the children in the main ward share a bathroom with epileptic women, with resultant discomfort, in spite of unceasing vigilance on the part of the management. In Metropolitan Hospital the toilet connected with Ward V is only to be reached by passing the doors of the isolation rooms, where contagious cases are kept. Precautions against the spread of vaginitis with such inadequate toilets and baths are of little avail, especially since the internes and nurses who examine the smears for traces of vaginitis are seldom trained for such work. The spread of vaginitis can only be prevented by such precautions as spray, or, at least, separate baths for any children sus-

pected of vaginitis; use of liquid soap; cheese-cloth or gauze diapers, which can be put in a paper bag and burned; sterilized pads; separate thermometers; and, most of all, frequent washing of the nurses' hands. In Cumberland Street Hospital 20 children had vaginitis at one time.

A dining-room for the convalescents is not necessary if a convalescent ward is provided. The present custom is to have the children eat in the diet kitchen, and in nearly every case this is hot and stuffy. The method of serving the food is especially important. The nurse too often goes away to her own luncheon just when the children are fed, and the scrubwoman who takes her place frequently spills food over pillows and bedclothes. The rule that the ward attendants should not handle the children should be enforced. The babies' formulæ are usually prepared in the maternity diet kitchen; Bellevue, only, has separate and adequate provision for this.

Isolation Rooms

These perform the important function in a hospital of caring for many of the children who are most dangerously ill, those awaiting removal by the Board of Health, and the surgical and medical cases which have developed an infection or a contagion but who are too ill to be moved. These small rooms are usually unworthy of the name of isolation.

In Harlem Hospital the room is located over the morgue, and is very difficult of administration, owing in part to the fact that all meals and supplies have to be carried a long distance. In Fordham Hospital the room is in a basement, with a northern exposure, near the examining physicians' office. On the day this room was inspected every patient who entered was cared for by the same nurse, who had just been handling infantile paralysis and chickenpox.

At Gouverneur Hospital the single, small room opens off the same corridor as the detention ward. It is dark and partly occupied by a piece of machinery, and there is no running water.

Proper and adequate isolation should provide at least the following precautionary devices and measures:

1. Each room should have a gown by the door to be slipped on by the nurse on entering.
2. Each room should have a washstand, arranged for the water to be turned on by elbow pressure, and the nurse should be required to wash her hands in running water with soap powder before touching a patient.
3. All equipment, such as bed pans, thermometers, etc., should be individual, to be used by patients only, and kept in each room.
4. Dishes when soiled should be sent back to the kitchen on a carrier and boiled before being touched by the kitchen attendants.

Sources of Cases

The district served by a hospital in so far as it relates to children's cases has been studied and the results are indicated on the accompanying maps. All the children's cases treated by the municipal hospitals in Manhattan and The Bronx for the year 1911 were tabulated, and the residences of such cases plotted on these maps. It will be noticed on consulting these maps that the children's cases cared for by Gouverneur, Harlem, and Fordham Hospitals were confined almost exclusively to the ambulance districts of these hospitals. The majority of cases going to Metropolitan

and City Hospitals on Blackwell's Island came from the ambulance districts served by these hospitals. A portion of the cases, however, were scattered through Manhattan. These scattering cases were largely transferred to the City hospitals from private hospitals. On the other hand, it will be noticed that the cases treated by Bellevue were broadly distributed over the entire district of Manhattan and The Bronx. A few cases came from Brooklyn, though the map does not contain the Brooklyn district. By count, about 50 per cent. of Bellevue cases came from outside of its own ambulance district, and were not transferred by other hospitals but were brought to Bellevue by parents, relatives, or friends. It is a noteworthy fact that the children going to the subsidiary hospitals of the Bellevue Department are almost exclusively confined to their ambulance districts, while those going to Bellevue proper come from the entire territory west of the East River. This situation may be partly explained by the fact that Bellevue is an old institution and well known, and has trained a large number of physicians throughout the territory whence the children come, and these physicians probably recommend that children be taken to Bellevue. It is a question whether such recommendations would be made by these physicians unless they had greater confidence in the children's service at Bellevue than at the other hospitals, some one of which would probably be much nearer to the home of the child. It is a fact that the service in Bellevue is much superior to that in the other hospitals, owing partly to the better facilities provided in the new building, but more largely to the employment of a resident children's specialist who devotes his entire time to the care of the children. Mothers have probably become aware that their children are better cared for in Bellevue, and this feeling and knowledge they transmit to their neighbors.

At least, from the above facts, this inference may be drawn: That a hospital furnishing high grade, satisfactory service for children will draw children from a much larger territory than that covered by its ambulances, as a mother seems willing to travel a long distance to visit her child in an institution where she feels it is well cared for. If this inference is well founded, the location of a children's service would seem much less material than the character of its equipment and treatment. A children's service or a children's hospital conveniently located in respect to transportation lines might reasonably be expected to attract cases from an extensive territory.

Accommodations for Children in Some of the New York Municipal Hospitals, and Findings in Regard to Same During Visits in 1913.

TABLE I.

ACCOMMODATIONS FOR CHILDREN IN SOME OF THE NEW YORK MUNICIPAL HOSPITALS, AND FINDINGS IN REGARD TO SAME DURING VISITS IN 1913.

TABLE I.

Name of Hospital	Present Bed Capacity of Wards		Census 1911	Census on 2 or More Visits at Intervals of 1 Week or More	Main Children's Ward Census on Same Days
Bellevue.	4 Medical Wards...	46 30 31 10	4,229	31, 44, 34 21, 22, 28 34, 29, 23 10, 5, 6	*Note.*—Bellevue has many children's wards and therefore is not typical.
	4 Wards annexed to Women's Surgical Wards.....	15 14 17 6[1]		17, 15, 18 14, 16, 18 15, 18, 18 7, 6, 7	
Fordham.	Main.....	42	1,388	39, 50, 36	21, 23, 23
	Detention.....	20			
	Isolation.....	3			
	Adult.....	6			
	Beds for babies as required in Maternity Convalescent Dining-room.				
Harlem.	Main.....	26	1,100	31, 26	17, 17
	Detention.....	4–5			
	Isolation.....	4			
	Adult.....	2–12			
	Beds in Maternity Ward as required.				
Gouverneur.	Main.....	30	1,182	29, 28, 31	28, 28, 31
	Detention.....	10			
	Isolation.....	3			
	Adult.....	2			
	Cribs and beds in Maternity Ward as required.				
Metropolitan.	Medical: Girls.....	26	679	16, 15	[2]11, 21
	" Boys.....	26			16, 15
	Surgical: Beds in Adult Wards as required.				Metropolitan is frequently in quarantine and it is difficult to obtain statistics.
	Whooping-cough and chickenpox in Women's Medical...	8			
	Vaginitis.....	8			
	Orthopedic and Tuberculosis:				
	Boys.....	37			25, 28
	Girls.....	16		28	16
City Hospital.	Main Ward.....	16	326	71, 72, 65	11, 13, 15

[1] Children formerly in Ward 12 now attended by same doctors but placed in Ward 7.

[2] There is no main children's ward in Metropolitan Hospital and these figures give the census of the general wards.

PHYSICAL EXAMINATION AND EMPLOYMENT OF DEPENDENTS IN CITY HOMES (ALMSHOUSES)

FOREWORD

History of the Care of Dependents—New York City[1]

In the early years of the City of New Amsterdam, about 1600, the poor were maintained at the expense and under the care of the Church. The fund for their support was collected by voluntary contributions made to the poor boxes and distributed by the officers of the Church. The needy were assisted in their own houses, and such as had no homes were provided with shelter in a house hired for the purpose. This house for a long time was located on the west side of Broad Street, just north of Beaver Street. Besides this poorhouse the City at this time was provided with a hospital. This hospital was built in 1658, when the population of the City was about 1,000.

The poor were assisted in about the same manner until about the year 1691, when the Church fund was increased by an appropriation from the public treasury; this fund was disbursed by the Mayor to poor persons recommended by the Aldermen, after due investigation by the City Constable.

In September, 1693, a poor law was passed by the Assembly, providing, among other things, for the appointment and support of a good minister in each parish or precinct, and also for the maintenance of the poor by a reasonable tax. In 1695 the General Assembly passed a law entitled, "An Act to enable the City of New York to relieve the poor and to defray their necessary and public charges." Pursuant to this law an inspector of the poor was appointed, and 100 pounds a year were appropriated for the maintenance and support of the poor. By the end of the year the fund had become entirely inadequate and further appropriation was made. The total for the year was 156 pounds sterling.

During the winter of 1713-14 the distress among the poor was very great. It was found by the Justice and Church-warden that they were perishing for want of clothing and provisions, whereupon a sum of 100 pounds was borrowed by the City for their support for six months. The proposition also was first made at this time for the establishment and building of a poorhouse, and a committee of six members of the Common Council was appointed to consider the matter. The appointment of the committee, however, did not result in building a poorhouse, and it was twenty years before any decided steps were taken in this direction.

According to the census of 1731 the City contained 1,400 houses and had a population of 8,628. There were many poor, including a proportionately large class of vagabonds and idle beggars. The poor were still boarded at the public expense, or wandered about begging. At this time, in 1731, the City suffered its third epidemic; smallpox raged with great fatality.

[1] The historical data set forth was compiled from:
Valentine's Manual.
Reports of the Commissioners of the Almshouse.
Reports of the Governors of the Almshouse.
Reports of the Department of Charities and Correction.
Reports of the State Board of Charities.

It became apparent that some means must be devised to meet these conditions, and, accordingly, the Common Council appointed a committee to inquire as to where a house suitable to be used as a workhouse might be purchased. This committee, after due investigation, reported on December 20, 1734, in favor of the erection by the Corporation of a workhouse. They recommended that it be placed on uninmproved lands belonging to the City, situated on the north side of the lands of the late Colonel Dongan, commonly called the "Vineyard." This recommendation was unanimously adopted by the Board and a committee nominated to carry out the measure. It was to be called "Publick Workhouse and House of Correction of the City of New York." The site was the ground on which the City Hall now stands. The building was begun in 1735 and was ready for occupancy early in the year 1736. It was 56 feet long and 24 feet wide, and contained two stories and a cellar. Within this small space were confined the maniac, the unruly, the poor, the aged, and the infirm. By 1746 the building was outgrown and required extensive additions and repairs.

In 1776, when the war broke out between England and the United States, the inmates were transferred to Poughkeepsie, there to remain until the close of the war. On the return of the poor at the end of the war additional buildings were erected to increase the accommodations. After the war the distress in the City was exceedingly great; the number of the poor was much larger than it had been; and the general tax very burdensome. A commission was appointed to investigate the Almshouse,[1] and, as a result, recommended a more economical management. In 1775 the poor tax amounted to 4,233 pounds; this, based on the census of 1773, was about .189 pound, or 95 cents, per capita. The Almshouse and Bridewell, located on the present site of the City Hall, were at this time under the immediate management of the Mayor and Recorder, in conjunction with the Vestrymen, the Aldermen, and Assistant Aldermen. The record of the census taken at the Almshouse on the 14th day of November, 1785, shows a total of 301, of whom 115 were males.

This house was occupied by the inmates until 1796. Two years before steps had been taken to erect a new building, the old one being then utterly unfit and altogether too small to meet the demands. To carry out this purpose, in January, 1794, the Common Council applied to the Legislature for authority to raise the sum of 10,000 pounds by means of a public lottery. This the Legislature granted. The site selected on which to build was in the rear of the grounds occupied by the old Almshouse building, on what is now the south side of Chambers Street, and on the site now occupied by the Courthouse. It was finished in 1796, and the paupers were removed to it on May 20th of that year. The number of inmates at the time of the transfer was 622, and only 102 of these were of native birth. Such is the history of the Almshouse down to 1811.

From 1794 to 1805 there occurred yearly epidemics of yellow fever, causing a considerable increase of poor and destitute. The Almshouse had become altogether too small, and in 1811 a special meeting of the Common Council was called to consider an offer which had been received from the heirs of the Kip family to sell a part of the old Kip's Bay Farm, located at

[1] The records are not clear as to the official titles of the City's early institutions, but inasmuch as the reference to Commissioners of the Almshouse in 1816 requires the capitalization of the name of that institution subsequent to the first mention of it, the same form has been followed in the designation of the others.—Editor.

the foot of 26th Street and East River. A committee was appointed at this meeting to purchase the site at a price not exceeding $3,500 an acre. The bargain was made a few days later on this basis. The survey showed that the plot contained over 6 acres, and that it was bounded northerly by Belle Vue Place, which already belonged to the Corporation in fee simple, and whereon there already stood the first building which was to bear the name, Bellevue Hospital. The corner-stone of the new Almshouse building was laid on July 29, 1811, and on April 22, 1816, the building was ready for occupancy. The buildings comprising the new Bellevue establishment were two hospital pavilions, the Almshouse itself, one workshop or factory designed as the Penitentiary, and a school. To the southward of the Almshouse stood the home of the Superintendent of the establishment, who was also one of the Commissioners of the Almshouse. The total cost complete, as reported to the Common Council on February 9, 1818, was $421,109.56.

In March, 1817, there were more than 200 patients in the Hospital. The number of paupers supported in the Almshouse varied in different seasons of the year, but in round numbers there were between 1,600 and 2,000. Notwithstanding the very large service of these institutions, the City was at this time confronted with an extremely grave problem; viz., the care of the alien poor.

Beginning with the eighteenth century there commenced an extensive immigration from Ireland. The immigrants were of the poorest and most destitute class, and so great was the poverty of these early immigrants that they were willing to sell themselves into peonage for the sum of ten pounds. The last sales of immigrants were reported in 1819 in Philadelphia.

In the Second Annual Report of the Managers of the Society for the Prevention of Pauperism in the City of New York, 1819, are the following statements:

> Through this inlet, pauperism threatens us with the most overwhelming consequences. . . . The present state of Europe contributes in a thousand ways to foster unceasing immigration to the United States. . . . An almost innumerable population beyond the ocean is out of employment. . . . This country is the resort of vast numbers of these needy and wretched beings. . . . They are frequently found destitute in our streets; they seek employment at our doors; they are found at the bar of our criminal tribunals, in our Bridwell, our Penitentiary, and our State Prison, and we lament to say that they are too often led by want, by vice, and by habit to form a phalanx of plunder and depredation, rendering our City more liable to increase of crimes, and our houses of correction more crowded with convicts and felons.

The condition above cited, coupled with an epidemic of yellow fever in 1819, caused a marked increase of persons applying for relief. It became necessary to build a hospital for contagious diseases, and such a hospital was built at Fort Stevens, on the Long Island shore, at Hallit's Point. This hospital was under the charge of the Bellevue physicians. Three years later another hospital for contagious diseases was built at Bellevue.

By 1826, following the suggestion of the Medical Committee of Investigation, of the previous year, the Common Council endeavored to find a place to which the prison might be removed. In 1828 Blackwell's Island was bought and a new Penitentiary building was begun, but not until 1836 was it ready for the reception of inmates, who, in the meantime, had been kept at Bellevue. The men were transferred first, but the women remained two years more, until the Tombs was ready to receive them.

During this period the conditions at Bellevue were far from ideal, as appears from the following communication of the Superintendent of the Almshouse to the Secretary of State, dated January 7, 1833:

I received yours of the 25th ult., with some blanks and the poor laws. I have delayed answering your communication, waiting for information relative to licenses.

The annual return from the Almshouse, I believe, was mailed the same date as yours, which I hope you received; there are no printed documents relative to the poor in the City of New York.

I have obtained a copy of the last annual report of the Comptroller which I send you.

From what experience I have had as Superintendent of the Poor for nearly two years, I have no hesitation in saying that the present system might be much improved. The number of male adults at present in the Almshouse is 572, out of which number there are not 10 who can be called sober. The number of female adults is 601, and I doubt whether there are 50 of them who can be called sober women.

I consider the present poor law as calculated to encourage intemperance from the fact that the moment they become habitual drunkards the public provides an asylum for them, at which they remain during their pleasure. When they are ordered at work many of them take their discharge. They soon become miserable objects about our streets and are sent again to the Almshouse, and by the time they get well, take their discharge, and so on, from year to year.

I believe that all persons whom the public support as habitual drunkards ought to be committed to a workhouse for at least 12 months, where they could be compelled to earn their living. When their time expires, if they take their discharge and again become intemperate, commit them again for 12 months, and so continue.

I send you a weekly return of our Almshouse, ending on the 5th inst., by which you will perceive we have 1,852 paupers, 1,017 of whom are natives (this last number includes all the children born of foreign parents), 835 foreigners, who travel here from all parts of the United States. There can be no doubt that the Almshouse originally was intended for old respectable poor; but as at the present organized, it has become an asylum for thieves, prostitutes, and the worst of the human family.

The police magistrates, by the present law, have the power to commit vagrants to the Almshouse, and in the exercise of that power they commit men and women who have in some cases been discharged from the penitentiary but a few days, and in some others, on the same day. The police, in my judgment, ought not to have control of the inmates of the Almshouse. They have in many instances committed persons for six months who were not residents of the County, and in some, where they were not residents of the State.

As early as 1830 a Special Committee on Pauperism was appointed to study the condition of the poor, and also to find a suitable site for a poor farm in connection with the Almshouse. On May 31, 1830, the Committee rendered its report, recommending the purchase of Great Barn Island (now called Ward's Island), but at the same time stating the following:

There are other locations to be had which may answer as well as Barn Island, and your Committee trust that the Board will not consider the project for a "poor farm" less likely to be successful because that special location cannot be procured at a reasonable price, and they would therefore invite your attention more especially to the system proposed, and would have the inquiry made whether Blackwell's Island cannot be cultivated upon a plan, which would give profitable employment to some of our paupers, and whether the lands now attached to the Almshouse (Bellevue Establishment) may not be more advantageously worked by them than they are now.

The consideration of the Board would be well directed in viewing the great advantages which may result to our Insane Establishment by the use of the extensive grounds.

The Board are aware that this peculiarly interesting and afflicted portion of our poor family are now inhabiting a part of the building nick-named "the fever hospital," where they are but poorly accommodated, and where their shrieks and agonizing noises are adding to the pains of those sick and dying poor who occupy

the greater part of the same building. Now if this City possessed a large farm, these lunatics could be separated from the present hospital establishment, when, if they had a building properly arranged for the classification of patients, and an occasional opportunity was allowed to such as may be fit subjects to indulge in tilling the earth, they would be much better off.

But the idea of establishing a poor farm was not carried out, and by 1837 the condition of the Almshouse, Lunatic Asylum, and Hospital was bad enough to shock the sensibilities of the Common Council and moved them to investigate it. The report of the Common Council conveys a vivid idea of the state of things.

In the Almshouse itself the female part was found in good order, furnishing a "silent rebuke to the contrast" in the other parts of the building. The adult males were in a filthy and ragged condition; the sick were in every part of the house; and, with the above exception, the whole department exhibited—to further quote:

evidence of neglect of the public interest and want of a proper regard to the subjects of misfortune. Complaints of poor and scant provisions, and unavailing application for relief were numerous and voluntary. Many were without shirts, and destitute of sheets and blankets, and such bedding as there was, was not clean. The building assigned to colored subjects was an exhibition of misery never witnessed by your Commissioners in any public receptacle for even the most abandoned dregs of human society. Here were scenes of neglect and filth, of putrefaction and vermin. Of system of subordination, there was none. The same apparel and the same bedding had been alternately used by the sick and dying, the convalescent, and those in health, and that for a long period. The situation in one room was such as would have created contagion as the warm season came on, the air seeming to carry poison with every breath.

In the Hospital were 265 patients, over one-half of whom were insane. The commissioners stated at the outset that they "will not enter into all the details of disgusting particulars witnessed in the Hospital. The condition of Bellevue Hospital was such as to excite feelings of the most poignant sympathy for its neglected inmates." The building, from cellar to garret, abounded in filth; the lack of proper ventilation deprived the wretched inmates of even the free gift of fresh air. Wards had not been whitewashed for two years, and the Hospital generally was in a condition manifesting great neglect and indifference toward its inmates. At this time jail fever appeared among the prisoners, and some cases occurred in the Almshouse. Many cases of the disease had been admitted to the Hospital and filled it to overflowing.

The Bellevue institution had, from time to time, got rid of various classes other than the sick. The first to be taken in this elimination process were the male prisoners, who went to the new Penitentiary building on Blackwell's Island, in 1836. They were followed in 1837 by the smallpox patients, who were taken to a small wooden building erected on the end of the island. The following year the female prisoners were sent to the Tombs, as has already been mentioned, and on June 10, 1839, the lunatics were removed to the new asylum on Blackwell's Island. The only institution left was the Almshouse.

On October 5, 1842, the Commissioners of the Almshouse addressed a communication to the Board of Aldermen in which they asked the attention of the Board to the very urgent call for enlarged accommodations in certain parts of the establishment under their charge. Their reasons were stated as follows:

The great increase in the number of applicants for the public bounties, and the alarming additions to the list of inmates in the Penitentiary require the most serious consideration. The present accommodations for both paupers and criminals are insufficient. Great as has been the recent increase of paupers, it is less in proportion than that of prisoners.

There were committed to the Penitentiary in August, 1842, 218 females, by the Magistrate, as vagrants; and in like manner, of the 128 in September, 1842, 120 were vagrants. The Penitentiary suffered from an overcrowded condition. The inconvenience was mostly felt in the want of accommodation in the Female Hospital. The poor, wretched inmates of this building were crowded together, thus impeding the chance of recovery and exciting the most serious apprehension of Prison or Typhus Fever.

The want of room in many cases had rendered it necessary to place three patients in two cots.

The Commissioners further recommended the building of a workhouse and almshouse on Blackwell's Island. This communication was referred to the Committee on Charity and Almshouse, but no action was taken. A few months later when the Commissioners rendered their annual report they again urged the necessity of erecting an almshouse and workhouse on Blackwell's Island. The workhouse, they stated:

Would be an establishment intermediary in its character between the Almshouse and Penitentiary, to which idlers and vagrants, and able-bodied drones may be committed and industrially employed, which may not partake of the degradation or reproach of a commitment to the Penitentiary, while it may work the penitential reform which that institution has failed to effect. A workhouse establishment for this purpose would be an institution for the punishment of idleness rather than crime. It would be, if properly conducted, a most efficient and powerful agent in checking the progress of vice, by arresting it in its incipient stage, ere idleness ripened into crime.

After many difficulties a Special Committee on the Reorganization of the Almshouse was appointed, which Committee, on March 6, 1843, passed a resolution providing for the erection of an almshouse proper; an adult and a children's hospital; an extension of the Lunatic Asylum; a workhouse on Blackwell's Island; and nurseries and an infants' hospital on Randall's Island. On May 8, 1843, the Commissioners of the Almshouse and Bridewell sent in their report to the Board of Aldermen, with plans for the buildings. It was not until 1848, however, that Bellevue got rid of its last attachment—the Almshouse.

On April 6, 1849, an act was passed by the State Legislature abolishing the office of Commissioners of the Almshouse and in place thereof creating the Almshouse Department of the City and County of New York, including therein the Almshouse proper, for the support and relief of the poor; the County Lunatic Asylum; the Nurseries, for poor and destitute children; the Penitentiary; the City Prison and Bridewell; and the other prisons and houses of detention in the City, with the hospital connected therewith. The act also provided that all these institutions were to be under the control and management of a board of governors, to consist of ten persons, to be named and styled "The Governors of the Almshouse."

The Board of Governors went earnestly to work, giving their earliest attention to Bellevue Hospital. They carefully examined into the principles of management of similar institutions, both in this country and abroad, and took counsel of eminent medical men in the City, as well as of the members of the Medical Board themselves, and, after thus inquiring into the reasons for and against, they determined upon a radical change in the medical management. The entire hospital was placed under the supervi-

sion of a non-professional warden, on October 1, 1849. New rules and regulations were adopted, and the house staff reorganized.

In 1850 the City expended for prisons and public paupers the sum of $421,882, and for paupers in private institutions the sum of $9,863, making a total of $431,745. This was the beginning of subsidizing private institutions for the care of dependents.

In 1861 the new Island Hospital (now City Hospital) was opened, and a large number of chronic cases were transferred from Bellevue to that hospital. The following appears in the report of the Warden of Bellevue to the Department of Charities and Correction, dated January 1, 1861:

> The determined effort to keep the Institution (meaning Bellevue) as free as possible from persons who were not fit subjects for hospital treatment has had a very beneficial effect; for, while we have not had many more patients in the Hospital at any time this year than last, there were treated and relieved here this year over thirteen hundred patients more than the year previous. The same system will have to be continued, as want of employment this season is certain to produce destitution and sickness.

A few years passed without any important changes. In 1867, however, by the demolition of the New York Hospital, supported by a private charitable organization, the City was deprived of hospital accommodation below Twenty-sixth Street, the small Emergency Hospital having been built on Twenty-sixth Street a short time prior thereto. The area south of that street comprised six square miles, and contained a resident population of 300,000 persons; but through the business hours of the day the population, gathered from all parts of the City and the adjacent country, was much larger than this number, and in this crowded and busy portion of the City the largest number of casualties occurred. To atone for the great public loss by the destruction of the New York Hospital the Legislature of 1868 directed the Commissioners to provide a Reception Hospital south of Grand Street; but because of an error in the language of the act the law was inoperative. The Legislature of 1869 corrected the error, and the Commissioners endeavored to find a suitable site, but were unsuccessful until the Commissioners of Public Parks assigned them the temporary use of a building in the City Hall park. In December, 1870, another Reception Hospital was opened at 99th Street.

The use of the City park building was indeed temporary, for shortly thereafter the building was condemned by the Tenement House Department and torn down, and this section of the City again remained without proper hospital accommodation. In the annual report of the Department of Public Charities and Correction for 1883 the Commissioners urged the immediate necessity of building a hospital on the lower east side, and one in the uptown district; and within two years following, Gouverneur Hospital, on the lower east side, and Harlem Hospital were established, relieving to a great extent the overcrowded condition existing at the time in Bellevue, Emergency, and 99th Street Hospitals.

By this time there was a very general feeling that the existing system under which the paupers, the criminals, the lunatics, and the sick poor were cared for by one department was highly objectionable and should be done away with. A bill was introduced into the Legislature providing for the division of the Department of Public Charities and Correction into four departments. This bill, however, was not passed, but the campaign for more adequate administration of the institutions then under the supervision of the Department of Public Charities and Correction did not cease, and

finally, in 1895, a law was passed providing for the division of this Department into two distinct bodies; namely, the Department of Public Charities, placing under its supervision the Hospitals, the Almshouse, Lunatic Asylum, and all institutions on Randall's Island; and the Department of Correction, to take charge of all penal and reformatory institutions. On February 1, 1902, the City Charter was further revised, and, pursuant to additional provisions, the control of Bellevue Hospital and its dependencies —Emergency, Gouverneur, Harlem, and Fordham Hospitals—passed from the Department of Public Charities to the Board of Trustees of Bellevue and Allied Hospitals. The managing Board of Trustees consisted of seven unpaid members, and the Commissioner of Public Charities as an additional member, *ex officio*.

A statement of the expenditure for dependents from 1850 to date follows:

Year	Population	For Prisoners and Dependents in Public Almshouses and Hospitals	For Dependents in Private and State Homes and Hospitals	Total	Expenditures per Capita of Population
1850	515,547	$421,882.00	$9,863.00	$431,745.00	$0.83
1860	813,669	746,549.00	128,850.00	875,399.00	1.07
1870	942,292	1,355,615.00	334,828.00	1,690,443.00	1.79
1880	1,206,577	1,373,383.34	1,414,257.00	2,787,640.34	2.31
1890	1,600,000	1,999,300.00	1,845,872.00	3,845,172.00	2.40
1900	3,437,202	2,760,780.97	3,079,259.60	5,840,040.57	1.69
1910	4,766,883	5,919,912.66	4,902,859.26	10,822,771.92	2.27
1911	4,973,000	6,487,420.16	4,800,857.00	11,288,277.16	2.26
1912	5,173,000	6,726,036.38	4,975,781.00	11,701,817.38	2.25

Expenditures for the care of Dependents exclusive of those in the correctional institutions:

Year	Population	Dependents in Public Institutions	Dependents in Private and State Homes and Institutions	Total	Expenditures per Capita of Population
1900	3,437,202	$1,998,005.97	$3,079,259.60	$5,077,046.57	$1.47
1910	4,766,883	4,648,562.76	4,902,859.26	9,551,422.02	2.00
1911	4,973,000	5,220,705.66	4,800,857.00	10,021,562.66	2.03
1912	5,173,000	5,426,599.38	4,975,781.00	10,402,380.38	2.01

It will be noted, by reviewing the figures in the foregoing table, that the expenditure per capita of population in the City for the support of prisoners, the sick, and the dependent, reached its maximum in the decade beginning with 1890, and was at that time $2.40. But by 1900 the expenditure per capita of population had been reduced to $1.69, and in 1912 it was $2.25. The decreased expenditure per capita of the population in 1900 and 1912, compared with 1890, does not indicate that less efficient service was rendered in the later years than formerly. Unquestionably the building accommodations, and the methods of caring for the sick and the dependent at the present time are much better than two decades ago. The reduced per capita expenditure was probably due to increased efficiency, since more service is being rendered to-day than twenty years ago. It would not seem

to be a wise policy on the part of the City, however, to reduce the amount devoted to the care of dependents because increased efficiency has lessened the cost. It would be a wiser policy to increase the standard of efficiency, and at the same time to expend the amount of money thus saved, in improving the physical plants, and in caring for the sick and poor.

The history of the development of the care of dependents given in the preceding pages makes it clear that methods have been markedly improved within the last hundred years, but the goal of adequate care has by no means been reached, and much more should be done to improve the surroundings in which our dependents pass their last days. The recommendations made in the report are designed to raise this standard, and the cost of carrying them into execution will probably not materially increase the per capita cost, if, at the same time, the recommendations for increased efficiency in the Department be put into effect.

THE INVESTIGATION

A cursory examination of the work done by inmates in the City Homes indicates that no systematic effort has been put forward to provide a variety of forms of work which might be adapted to the physical and mental ability of the inmates. A certain proportion of the inmates, those who are considered by the superintendents of the institutions to be able to do physical work, are employed in helping to care for the buildings and grounds, but the amount of industrial work provided for inmates unable to do work about the buildings is quite limited.

The City Home, Manhattan, has a broom shop, but it is operated to a very limited degree. One man is employed, and a few inmates at times help him. At the time of examining the work, June 9, 1913, 1 man was occupied in the shop. At this same time 3 men were employed in mattress-making; 2 men in the tin shop; 4 men in the carpenter shop; and 4 men in the shoe shop. The number of women in the sewing room varies. The bulk of the sewing, however, is done by paid women.

In the City Home, Brooklyn, about 10 men are occupied at mattress-making; 6 in making bandages; 3 in repairing shoes; 3 to 5 in the carpenter shop; and 10 or 12 men in the tailor shop. Nearly all of the sewing is done by inmates, from 30 to 50 women being occupied in this way.

At Farm Colony usually about 3 men are occupied in the shoe shop; 1 to 3 men in making harness; 5 to 10 men in the carpenter shop; and about the same number in the tailor shop. From 15 to 20 women are occupied in the sewing room. Since January 1, 1913, a man has been employed to teach rug making, and about 60 men have been engaged in this work.

A much larger number of inmates are employed in performing work connected with the Colony, such as cleaning, making beds, work on the grounds, in the power house, laundry, and a large number of miscellaneous tasks. At the Manhattan Home an average of about 600 people are thus employed; at the Brooklyn Home about 500; and at Farm Colony about 400.

The total number employed in any one of the institutions, whether at industrial work or in caring for the institution, is not a major proportion of the total inmates in the institution. It is the belief of some of our most enlightened almshouse experts that it is possible and advisable to furnish employment for every inmate not actually sick in bed. A large proportion of the inmates in the almshouses in New York City are apparently unable to do heavy or even moderately heavy work, but they are apparently able to do a variety of light industrial work that would require little exertion and effort. Thus far there has been no systematic attempt made to ascertain the number of people that could be so employed, or to devise means and methods of employing such.

At no time, either during the process of admission or after arriving in the institutions, is a physical examination made of the inmates to determine their condition or ability to work. An examination is made of applicants at the office of the Manhattan Bureau of Dependent Adults, but this examination is limited to a very superficial test to determine whether the applicant should be sent to one of the hospitals of the Department or to an almshouse. The examination is not of a character to determine the physical

condition of a person not evidently sick. After these dependents arrive in the institutions as inmates they are assigned to the hospital wards, the wards for the infirm and crippled, or to the dormitories, on the judgment of the Superintendent, who, in both the Manhattan Home and Farm Colony, is a layman. In the Brooklyn Home, though nominally the Superintendent of the Kings County Hospital is Superintendent of the Home, the major part of the administrative duties are actually carried on by a subordinate officer, who is a layman, and the work of distributing the inmates is performed by this layman.

The determination of which of the inmates is or is not able to work rests with the lay superintendent. The result is that in many cases men who are amply able to work will not do so, on the claim that they are unable because of physical disability, and the Superintendent, fearing lest his judgment may be wrong, accepts the excuse of such unwilling inmates. In other cases men who are willing are put to work, on the supposition that they are able because they are willing, when a close examination would show that such men, if put to work at all, should be occupied only with light, sedentary labor. Corroboration of the above statements will be found in the record of inmates physically examined, set forth on subsequent pages.

Farm Colony was established in 1902, for the purpose of sending to this place all inmates who were relatively able-bodied and able to do the various types of work in connection with operating a farm. This original program was adhered to for the first few years, and then those less able to work were also sent to the Colony. The classification of the Department now shows that over 34 per cent. of the inmates of the Colony are crippled, deformed, or senile.

The need of medical attention by any inmate is not determined by a regular system of examination or inspection, but by the fact that an inmate does not get up at rising time. When an inmate remains in bed and complains of being sick the fact is reported by the dormitory attendant and a physician makes an examination. But many persons are sick and in need of medical attention who do not remain in bed. As is well known, many persons will not complain when feeling far from well, and when they are evidently in need of medical care. This is quite as true of inmates of almshouses as of those who are not so unfortunate as to be dependent upon the public for support.

The above recited conditions, viz.:

1. That inmates were admitted without full physical examination;
2. That inmates were not physically examined after reaching the institutions;
3. That inmates were put to work, or allowed to remain idle, solely upon the judgment of a layman as to their physical ability;
4. That no systematic method of determining the degree of health or sickness of the inmates existed,

prompted your investigator to have a thorough physical examination made of a reasonable proportion of the inmates of the Homes to determine:

(a) The relative proportion of the inmates who were sick, infirm, or crippled;

(b) The proportion, who, though not able-bodied, yet were able to do light industrial work;

(c) The proportion that were relatively able-bodied and able to do a fair amount of work daily.

This examination was placed under the charge of Dr. L. L. Williams, Medical Investigator for the Committee. Dr. Williams has gained broad experience in such matters through his activity at Ellis Island, the medical work of which station he now has in charge. His report, which is contained on subsequent pages, describes the method of examination and the results obtained.

The extended and careful physical examination of the inmates carried on by Dr. Williams has shown that about 60 per cent. of the total inmate population is probably able to do work, ranging from heavy farm tasks to light industrial employment. Sixty per cent. of the total population would represent about 3,000 inmates. At the present time there are daily employed in the three City Homes not to exceed 1,500 persons. It would seem, therefore, that an estimated number of about 1,500 inmates who are now idle could do some form of light work if suitable devices and machinery were installed. Such employment would probably yield a return that should more than offset the cost of machinery necessary to provide employment, and, at the same time, would contribute largely to the contentment, happiness, and well-being of the inmates.

To ascertain the extent to which inmates in almshouses in other cities and states are now employed, and the nature of their employment, an inquiry was made of some of the leading Almshouses in Massachusetts, Rhode Island, Pennsylvania, Ohio, Illinois, and Missouri. A large percentage of the inmates of the Almshouses in Massachusetts were employed, but inasmuch as the Almshouse population is housed in the same institution with the insane and vagrants, it was impossible to ascertain what proportion of the work was done by the dependents and what by the other classes. Some information of value was secured from the Almshouses in Philadelphia and St. Louis. The Almshouses in the other states had developed industrial work in but a minor degree, and, therefore, had little to offer in the way of suggestions. Where special attention had been given to the employment of inmates the institutional management claimed that the value of the product of the inmates much more than offset the cost of machinery necessary to employ them and supervision for the purpose of instructing them.

THE EXAMINATION

BY

DR. L. L. WILLIAMS

MR. HENRY C. WRIGHT,
Director of Hospital Inquiry.

SIR:—

In compliance with your request, a tentative memorandum for the use of physicians who may be employed in making physical examinations of the inmates of the City Homes of the Department of Public Charities has been prepared; the memorandum, including an occupational index and form of medical record, is appended hereto.

In accordance with this scheme of examination, 512 inmates of the City Home, Blackwell's Island, have been physically examined. The examinations have been made by Dr. John H. Carroll, whose work has resulted in the accumulation of material of much practical and scientific value. In making the examination various groups of inmates were selected, and an effort made to examine a sufficient number in each group that would seem to be a fair cross section of the institution. At the request of the Commissioner of Public Charities the examination has been confined to male inmates.

This examination had a two fold object: First, to classify these inmates on the basis of their physical and mental capacity, in order that some criterion might be established for their assignment, in accordance with their actual condition, to either the hospital wards or to various occupations in the City Homes. Second, that the percentage of morbidity among the inmates of the Homes might be ascertained and the question of the necessity for a more comprehensive medical supervision of all the residents in these institutions be given consideration in the light of the actual facts.

The inmates examined were in three general classes: First, those who are deemed proper subjects for active medical treatment, and are designated for admission to the medical, surgical, or neurological wards. Second, those who by reason of age, incurable disabling disease, deformity, the results of injury, or mental incapacity, are designated for care under medical supervision in wards for the infirm and crippled. Third, those who are either free from actual disease, or who are the subjects of disease of a chronic character which does not wholly incapacitate them, and who are designated for occupations of various kinds.

The occupational index, constructed for the purpose of still further classifying the last named group of inmates, divides occupations into two groups, heavy work and light work. For convenience in classification these two groups are subdivided, and under the head of heavy work are placed heavy farm work, heavy mechanical work, and domestic work; under the head of light work are placed light farm work, light non-sedentary mechanical work, and light sedentary mechanical work. Examples are given in the occupational index.

The proportions of the number examined, with suggested assignment, are shown in the following table:

RESULT OF PHYSICAL EXAMINATION OF DEPENDENTS IN CITY HOME, MANHATTAN (BLACKWELL'S ISLAND).

	Number Examined	Percentage of Total Number Examined
ASSIGNED TO OCCUPATIONS:		
Group I.		
Heavy Farm Work	22	4.3
Heavy Mechanical Work	42	8.2
Domestic Work	37	7.2
Group II.		
Light Farm Work	19	3.7
Light Mechanical Work—Non-sedentary	31	6.1
Light Mechanical Work—Sedentary	149	29.1
Total Number Assigned to Industrial Work	300	58.6
ASSIGNED TO HOSPITALS:		
Assigned to Medical Wards	76	14.9
Assigned to Surgical Wards	21	4.1
Assigned to Neurological Wards	18	3.5
Total Number Requiring Active Treatment	115	22.5
Assigned to Wards for Infirm and Crippled	97	18.9
Total Number Requiring Medical Care	212	41.4
	512	100.0

While the majority of the inmates examined were persons who had resided in the institutions for longer or shorter periods, 78 newly admitted inmates were also examined; these are included in the total number represented in the table. Of the new admissions, 33, or 42.4 per cent., were assigned to the hospital; 45, or 57.6 per cent., were designated for industrial occupation. It should be explained that this examination was made in the spring, when fewer persons seek admission than in the fall and winter, and when those who do apply probably show a higher percentage of actual disability. Among those found to be in need of medical care, and who were designated for admission to hospital, were 4 persons who are now required to perform labor in the Home.

Such instances exemplify the propriety of a careful physical examination before assigning inmates to occupations, as well as the advantage of medical supervision after such assignment. Many of these persons, for their own good, should be put at work of some kind; not only should care be taken to assign them to occupations proportioned to their strength, but they should also be under observation afterward, in order that they may be removed to the hospital section when it becomes apparent that they are no longer fit for labor.

Of active pulmonary tuberculosis, 15 cases were found among the inmates examined. The finding of cases of this kind in congested barrack rooms accentuates the necessity for a careful examination of all inmates.

As the older inmates need glasses for correct vision, and all are not provided with them, it would seem proper that glasses be furnished by the City for those needing them. Such provision would add to the comfort of these inmates, and is essential for those assigned to certain kinds of work.

It is of interest to compare the results of this examination with the classification of inmates of the New York City Home in the Annual Report of the State Board of Charities for 1911 (page 128), which states as follows:

"The total number of inmates, September 30, 1911, was 2,675. Of these, 1,246, or 46 per cent., were classed as able-bodied; the remainder, 54 per cent., were classed as sick or infirm, feeble-minded or idiotic, epileptic, blind, or deaf." This examination finds the proportions somewhat different than those reported by the State Board of Charities. The sick, infirm, etc., constituted 41.41 per cent., and those able to do some work, 58.59 per cent.

It has been found, however, that 52.8 per cent. of the persons designated for industrial work—especially the lighter varieties—suffer from actual disease. Many others in this class, while not obviously diseased, are more or less infirm, on account of age, alcoholic habits, etc. None of these can fairly be classed as able-bodied, in the usual sense of the term, except those assigned to heavy work (who constitute 19.7 per cent., as shown in table, Group I). Even in this group some of the inmates assigned to domestic work (Group I, No. 3 of Occupational Index) are only relatively active or able-bodied. A stated proportion of 46 per cent. able-bodied persons would, therefore, unless qualified, give an erroneous impression, if the results of this examination of a portion of the inmates gives a fairly accurate index of the morbidity in the entire institution.

Of the 300 inmates of the Home regarded as fit for occupation, mainly light work, 209, or 69.6 per cent., suffer from chronic diseases of various

kinds. Many of them, for instance, have disease of the heart, "compensated" at present, but liable to require treatment at any time. Adding this number to those assigned to the hospital wards we have 421 inmates who are afflicted with disease or injury of some kind, or a total morbidity of 82.2 per cent. of the entire number examined. With such a percentage of morbidity, and, considering the fact that many of the inmates who are free from definite disease are old and more or less infirm, it seems advisable that the entire institution, the barracks as well as the infirmary wards, be subject to medical visitation at frequent intervals. These people, belonging, as they do, to the army of the "down and out," accustomed to institutional routine and to submit to authority without question, are indisposed—many of them at least—to voluntarily exploit their ailments. A plea is made for such medical supervision of the institution as has been suggested, and it is believed that such provision will commend itself to all who give consideration to the facts and who are alive to the necessity of conserving the interests of those who, because of their unfortunate condition, are deprived of a voice in that which most concerns them. Considerable labor will be required in the first instance to make a physical examination of all inmates. Once this is accomplished, however, and the records indexed, the examination of those admitted daily and the necessary medical oversight of all inmates will not require a large force or involve any heavy outlay. In the process of examining somewhat over 500 inmates it was found that the physical examination indicated by the appended instruction and blanks could be performed, on an average, in about fifteen minutes for each individual. In some cases, in which the physical condition was evident, the time required was smaller, and in other cases, where it was necessary to make more tests, the time required was longer. In the whole number of cases, however, the average was about as indicated. It may be assumed that should the Department undertake to physically examine, to the extent used in this experimental inquiry, all inmates taken into the institutions, the time required day by day would average about 15 minutes per inmate.

Respectfully yours,

L. L. WILLIAMS, M.D.

Memoranda for Medical Examiners

The objects of the physical examination and classification of the inmates of the institutions of the Department of Charities are:

1st. That the dependent poor of the City may be divided into groups with a view to their distribution in the several institutions under such conditions of care and occupation as may be most conducive to their mental and physical well-being.

2nd. That the cost of their maintenance may be reduced by the products of the various occupations to which some of them may be assigned, such assignment to be governed primarily by consideration of their own best interests.

3rd. To relieve the supervising officers of the several institutions of responsibility in assigning inmates to occupations, especially to those of a laborious character.

Statement of Inmate or Relatives

Upon the admission of an inmate to the reception ward obtain from him, or from his relatives or friends, all the information available which may throw light upon his present condition. This statement should include the inmate's age; sex; family history, especially as to insanity; nervous disease or tuberculosis; occupation; habits, as to the use of alcohol or drugs; previous diseases from which he may have suffered; present disability, if any.

Routine Physical Examination (All Cases)

A preliminary examination, without removal of clothing, will be sufficient to determine the groups into which a considerable proportion of the inmates would fall and the kind of work for which they are best fitted; a more extended examination being reserved for cases in which there is doubt as to the proper classification, or in which there is some obvious indication for a more searching inquiry.

At this initial examination the following points should be noted and recorded:

Physique, whether robust, good, fair, or poor; nutrition, whether well or poorly nourished, obese or emaciated; color; obvious disease or deformity; obvious disordered movements; character of breathing; pulse, as to rate and character; arteries, as to apparent tension or degree of rigidity; muscular power and freedom of mobility of joints of upper extremity, of lower extremity, and of spine; obvious abnormal conditions of eyes and acuity of vision in each eye; acuteness of hearing and obvious abnormal conditions of ears; abnormal conditions of nose, mouth, and throat; defects of speech; obvious mental defects.

The inmate should be questioned as to the existence of any disability, and his statement as to the alleged presence of diseased conditions verified in every instance.

The physique, nutrition, and color will give valuable indications as to the state of the general health; a markedly frail physique, malnutrition, or a dusky, congested, pallid, or yellow skin, should be regarded as sufficient indication for a careful inquiry into the condition of the thoracic and abdominal organs.

The neck should be examined for goitre, enlarged glands, or pulsating veins.

The muscular power and mobility of joints should be tested by causing the inmate to execute certain movements. The following movements are suggested to be carried out, wholly or in part, in the discretion of the examining officer:

Upper Extremity: Clasp hands above head and behind back; circumduct humerus; strike from shoulder; flex, extend, pronate, and supinate forearms; flex and extend wrists; open and close hands; spread fingers; test strength of grip in each hand.

Spine: Extension; flexion, with knees held in extension; lateral movements; rotation.

Lower Extremity: Simultaneous flexion of legs and thighs (sitting on heels); rise on toes; abduct, adduct, and rotate thighs. In the case of women some of these movements may be omitted or modified, especially if there is good reason to do so, such as apparent defect of movement of

the lower limbs, or complaint of disability on the part of the inmate. In such cases the examination may be more conveniently conducted while the inmate is in bed. During the execution of these movements note especially the degree of mobility of the spine, indications of flat foot, the existence of crippling deformities of the joints, or evidences of dyspnœa or exhaustion. The manner in which the above-named movements are executed, taken in connection with the general appearance and physical development, should enable the examiner to form a fair estimate of the inmate's muscular power and fitness for work.

In selected cases (fairly able-bodied men) the inmate's agility may be tested by causing him to run back and forth across the room several times, to hop alternately on each foot, and perform similar exercises which will readily suggest themselves.

While these tests are in progress the rate and character of the breathing should be noted, and the test discontinued if there is dyspnœa or any sign of exhaustion. The pulse rate should be taken, and the character of the pulse and the condition of the radial artery noted. In determining the condition of the arteries, as to elasticity or rigidity, it will be well to examine the brachial artery, as well as the radial or temporal.

In the course of the examination any paralysis, whether general or local, incoördination or convulsive movements, tremor and limitation of movement from deformity or disease of joints will become apparent. Crippling diseases of the hands, chronic arthritis, varicose veins, contractures, muscular atrophy, etc., should be carefully looked for.

The gait should be noted, whether normal, ataxic, spastic, staggering, hemiplegic, etc.

Eyes: The acuity of vision in each eye should be roughly tested with the Snellen types, when practicable, and all cases of marked defect of vision not due to known incurable conditions should be referred to the eye clinic for expert examination and correction by glasses or otherwise. Note on the record any disease of the eye or its appendages discoverable by ordinary inspection, and refer to the clinic all cases of curable disease or suspected disease. Particular attention should be given to the examination of the lids for trachoma, in order that precautions may be taken to prevent the spread of infection by inmates suffering from this disease.

Ears: Test the acuteness of hearing by the conversation test. This may be supplemented, when desired, by testing each ear separately with the watch. Note the presence of disease or deformity of the external ear, discharge from the ear, or tenderness over the mastoid. Persons with obvious disease or suspected disease of any part of the auditory apparatus should be referred to the clinic.

Mouth, Throat, and Nose: Note abnormal conditions present. Refer cases to clinic when necessary.

Speech, Defects of: Carefully note all defects of speech, such as aphasia, paralytic defect of articulation, scanning, etc., which may be of value in the detection of nervous lesions and in estimating the degree of mental development or deterioration.

Mental Condition: In the course of the examination a fair estimate of the inmate's general intelligence should be gained. His general behavior, attitude, quickness of apprehension, peculiarities of conduct or language, emotional outbreaks, loquacity or taciturnity, disordered movements,

condition of pupils, and peculiarities of gait will all give valuable information as to the presence of mental defect or deterioration. In many instances departures from the normal will not be detected until the inmate shall have been under observation for a time, when his personal habits, peculiarities of conduct, etc., will call attention to his condition.

For practical purposes abnormal mental conditions may be classified under the following headings:

Mental development:
Normal. Feeble-minded. Imbecile. Idiot.
Mental deterioration:
None. Slight. Marked.

To be Included in Examination Before Recommending Laborious Occupations

Inmates who upon preliminary examination appear to be able to perform work involving considerable muscular exertion should not be designated as fit for such work until the organs of the chest and abdomen have been carefully examined and the presence of serious disease excluded. The movements named in the physical examination should be fully carried out and the blood pressure taken.

Chest: The examination of the lungs and heart may best be done immediately after the physical exertion involved in the tests for muscular power and mobility of joints. In addition to the examination by the usual methods, the shape and mobility of the chest should be noted, and measurements taken after full inspiration and expiration, the vital capacity being taken with the spirometer, if desired. Evidences of dilated heart, emphysema, or other lesion likely to seriously limit muscular exertion should be carefully looked for.

Abdomen: With the subject erect, examine each inguinal canal for hernia; note the appearance, muscular sufficiency, and whether there is ptosis of viscera. The presence or absence of hemorrhoids should be ascertained.

With the subject preferably in the recumbent position, examine for evidence of intra-abdominal disease.

Further Physical Examination (When Indicated Only)

A more comprehensive examination will be required when called for by indications arising during the preliminary examination; such, for example, as evidences of disease or deformity of spinal or other joints, evidences of chronic nervous disease of doubtful character, or suspected syphilitic disease.

Inspection

The surface of the body should be inspected after the clothing has been removed, wholly or in part, as may be necessary, noting the general muscular development; the presence of eruptions, ulcers, or scars; glandular enlargements, especially in the epitrochlear and inguinal regions; varicose veins; deformities, their nature and extent; evidences of former disease or injury of bones; evidences of self-administered hypodermic injections.

Genito-urinary System

(a) In women, assume to be normal, unless there has been complaint from inmate or report from relatives, or unless evidence of pelvic disease

has been obtained by the previous abdominal examination. If special examination is necessary, refer inmate to the gynæcological clinic.

(b) In men make superficial examination and note presence of obvious disease or abnormality of external organs. Otherwise assume to be normal, unless there has been complaint from inmate or report from relatives or attendants.

For any necessary special examination refer to clinic.

Reflexes

Examine pupillary reflexes, and note presence or absence of knee-jerk, ankle clonus, Babinski sign, or Romberg sign.

Laboratory Test

(a) In all cases

Urine: As a routine measure the examination may be confined to the following: reaction; specific gravity; qualitative tests for albumin and for sugar; microscopical examination of sediment, if any is present; Wassermann test when indicated.

(b) When indicated only

Hæmoglobin: The percentage should be taken, preferably by one of the rapid methods, such as the Tallqvist scale.

Complete laboratory examination of urine and blood may be undertaken when called for by special indications obtained during the routine physical examination.

Sputum: This should be submitted to microscopic examination if there is cough with expectoration and the physical examination of the chest leads to suspicion that tuberculosis may be present.

In General

The object of the examinations should be constantly borne in mind; viz., the betterment of the inmate's environment, as a primary consideration, and, secondarily, his return to comparative usefulness.

The preliminary examination will suffice for the elimination from further examination of those who are obviously able to work, and those who are evidently sick or disabled, the more complete examination being reserved for doubtful cases.

Note and record any condition found during the examination which may bear upon the inmate's capacity for work, and which might be of assistance in determining the kind and degree of labor he could safely perform.

The examination should be terminated as soon as it becomes evident that the inmate should be sent to hospital. It should also be discontinued when it gives rise to marked emotional disturbance. In such cases it may be resumed after a period of observation.

Except in cases in which there is doubt whether the inmate should be sent to the hospital the examination may be abruptly terminated as soon as it becomes apparent that he should be grouped in a certain class. This applies particularly to inmates suffering from certain obvious and incurable conditions which manifestly limit their working capacity, but for which nothing can be done in the way of treatment.

In completing the record form give a résumé of the results of the examination, in the form of a diagnosis, and make recommendations as to the disposition to be made of the inmate, in conformity with the subjoined schedule: (In case a diagnosis is obvious it will be unnecessary to fill out many of the details of the blank. In some instances, in which there is an obvious terminal disability of doubtful origin, the diagnosis may be recorded in general terms, which should be sufficiently explicit to indicate the nature of the disability without necessarily entering into questions of causation or pathology.)

Recommendation to be Made

(1) To be sent to hospital.
- A. Medical: Acute Chronic
- B. Surgical: Acute Chronic
- C. Neurological.
- D. Wards for Infirm and Cripples.

(2) Occupational Index. Group 1: Nos. 1 2 3

(3) Occupational Index. Group 2: Nos. 4 5 6

The number of hours' work per diem deemed suitable in each case should be included in the recommendation, and, when practicable, several occupations should be designated by their appropriate numbers, due regard being had to the inmate's predilections and previous occupation.

In case of failure of the inmate to fit the environment recommended he should be reported to the medical examiner for further examination and recommendation.

An occupational index is appended for the information of medical examiners.

A record blank suggested for use in recording the results of physical examinations is appended.

The record is to be filed, and subsequent data of a pertinent kind, whether of a medical nature or bearing upon the inmate's adaptability to certain kinds of work, may be added from time to time.

The official number of the inmate should be recorded on the form.

Upon the death, discharge, or transfer of the inmate, the date will be recorded and the record permanently filed.

If readmitted there should be cross references on the old and the new form, making a continuous record in each case.

Occupational Index

Group I.—Heavy Work.

1. *Heavy Farm Work;* such as,
   - Plowing
   - Harrowing
   - Harvesting
   - Milking
   - Teaming
   - Stable Work, etc.
2. *Heavy Mechanical Work;* such as,
   - Masonry
   - Road Making
   - Carpentering
   - Plumbing
   - Steam Fitting
   - Gas Fitting
   - Fire Room, etc.
3. *Domestic Work;* such as,
   - Laundry
   - Kitchen
   - Dining Room
   - Care of Wards
   - Cleaning
   - Care of Grounds, etc.

Group II.—Light Work.

4. *Light Farm Work;* such as,
   - Planting
   - Weeding
   - Care of Stock
   - Poultry Yard
   - Fruit and Vegetable Canning
   - Care of Lawns, etc.
5. *Light Mechanical Work, Non-sedentary;* such as,
   - Cabinet Making
   - Upholstering
   - Painting
   - Tin Shop
   - Tool Repairing, etc.
6. *Light Mechanical Work, Sedentary;* such as,
   - Sewing Room
   - Knitting
   - Mat Making
   - Basket Making
   - Broom Making
   - Tailor Shop
   - Clerical Work.

MEDICAL RECORD OF INMATES.

Record No.....Institution.....
Name.....Sex.....Age.....Occupation.....
Habits: Alcohol.....
Drugs..... Family History.....
.....
Previous Diseases.....Present Disability.....
Phys. Exam: Physique.....Nutrition.....Temp.....
Obvious Disease or Deformity.....
Eyes.....Ears.....Skin.....
Nose.....Mouth.....Throat.....
Chest: Mobility..... Inspiration.....In. Expiration.....In.
Heart.....Lungs.....
Blood Pressure.....Arteries.....Veins.....
Abdominal Organs.....
Muscular Power and Mobility of Joints.....
Genito-urinary Organs.....
Nervous System.....
Reflexes: Pupillary.....Knee Jerk.....
Babinski.....Ankle Clonus.....Romberg.....
Mental Development: Normal. Feeble-Minded. Imbecile. Idiot. .....
Mental Deterioration: None. Slight. Marked. .....

[OVER]

(*Reverse side*)

.....
Lab. Exam.: Hæmoglobin.....Sputum.....Wassermann.....
Urine: Spec. Grav.....Reaction.....Albumin.....Sugar.....
Remarks: .....
.....
Diagnosis.....

RECOMMENDATION:

1. To be Sent to Hospital
   - A. Medical Acute
     - Chronic.....
   - B. Surgical Acute.....
     - Chronic.....
   - C. Neurological.....
   - D. Wards for Infirm and Crippled.....
2. Occupational Index. Group 1 Nos. 1.....2.....3.....
3. Occupational Index. Group 2 Nos. 4.....5.....6.....
4. To be Held Temporarily as: Alien.....
   - Non-resident.....

Number of Hours Work per Diem.....
Subsequent Data.....
.....
.....
Transferred).....
Discharged).....19.....
Died).....

EMPLOYMENT

The almshouse for the City of St. Louis, Mo., is located within the City. It is surrounded by about 7 acres of ground, used for gardening. The average number of inmates during 1912 was about 675. Of this number, about 500 were employed daily for a period averaging 5 hours per individual. Thus, about 73 per cent. of the total population are occupied, and serve in the institution in some useful way. These inmates work for 2½ hours in the morning, and then have a rest period of about 3 hours, followed by 2½ hours of work in the afternoon. They are occupied in cultivating the garden in connection with the institution, and in the care of the buildings and grounds. They perform nearly all the services in the buildings, doing all of the laundry work, all of the sewing, and make all of the clothes and shoes for the inmates. They operate a soap factory, in which not only the soap for the institution is produced, but additional soap for other city institutions. All mattresses used in the institution are made by the inmates, and besides, a certain number are sold to other City institutions. A carpenter shop is operated, in which there is manufactured a good proportion of the furniture used in the institution, and in addition to the carpenter work in the shop, repairing is done to the buildings—this activity alone during the last two years having aggregated in value about $50,000. A bookbinding shop is operated, in which magazines and books are bound for the library of the institution. The library at present numbers about 3,000 volumes, all of which have been bound by the inmates. The inmates also erected an entertainment hall, about 60 x 80 feet in size, and manufactured for it sufficient seats to seat approximately 700 people. They constructed a large fountain for the grounds; laid the water-main; and have done many pieces of constructive work which in most institutions are done by outside labor.

The superintendent of the institution, Mr. W. A. Anderson, stated that comparatively little difficulty is found in inducing the inmates to work, and that an atmosphere of contentment and happiness exists which is not usually found in institutions where inmates are not daily occupied. Our investigator was convinced that the statement of the superintendent with regard to the contentment of the inmates was true. There seemed to be a greater atmosphere of contentment and happiness, and coöperation between the officers, employees, and inmates, than at any other almshouse visited. This he attributed most largely to the occupation of the inmates. Every inmate, when entering the institution, is given to understand that he will be expected to labor daily, unless he is considered by the physician in attendance to be unable to perform labor.

The almshouse for the City of Philadelphia is located within the City, on a plot of about 20 acres, which is largely occupied by the buildings of the institution, very little ground being devoted to gardening. The plant itself is old and out of repair, badly adapted to its purpose, and much overcrowded. Regardless of its crowded condition much industrial work is carried on. Its average population in 1912 was about 1,270, of which

about 725 were men, and 545 women. The men are not only employed in the wards occupied by the almshouse, but also in the insane asylum, children's hospital, and the general hospital. The inmates are not allowed to serve outside of the almshouse proper, or the grounds, so that the number who are employed at labor is considerably restricted. Of the 725 men, about 600 were employed daily. Of the 545 women, only about 130 were employed daily. In addition to doing the general work of the various institutions mentioned, which harbor about 7,000 inmates, the men are employed at weaving, making shoes, clothing, mattresses, brooms, and printing reports and forms, for their own and the Health Department's use. At these various occupations about 82 per cent. of all the men in the institution are employed.

Although a large proportion of the men in the institution are employed, there was not the same degree of contentment noted in this institution as in some others, probably owing to the fact that the overcrowded condition rendered them somewhat uncomfortable. The overcrowded condition will be relieved comparatively soon by two new institutions which are to be built, one of which is now under process of construction.

Most almshouses are located on farms, probably for the reason that the inmates can be more readily employed at farm than at mechanical labor. These farms generally raise standard crops, which do not require a great amount of labor. The return per acre does not vary greatly from that of the average privately worked farm.

The value of products on some almshouse farms in New York State is set forth below:

VALUE OF FARM PRODUCTS PRODUCED BY INMATES OF ALMSHOUSES OF NEW YORK, 1911.

	Acreage Under Cultivation	Inmates	Value of Products	Value per Capita	Value per Acre
Allegany County	183	59	$8,814.10	$149.39	$48.16
Delaware "	80	39	5,334.20	136.77	66.67
Franklin "	100	35	6,891.54	196.90	68.91
Genesee "	155	51	8,625.43	169.12	55.64
Oswego City	47	36	7,623.71	211.77	162.20
Ontario County	180	59	9,544.24	161.76	53.02
St. Lawrence County	150	78	13,144.71	168.51	87.63
Wyoming "	180	40	12,244.38	306.10	68.02
Yates "	165	34	6,847.96	201.41	41.50
Farm Colony, New York City	70	703	11,768.72	16.74	167.40

A review of the figures of the preceding table will show that the average value of products per acre of almshouse farms is about $60. Two of the farms exceeded $100 per acre, of which two Farm Colony of New York City stands the highest, with $168 per acre. None of the farms other than Farm Colony is devoted exclusively to truck gardening. Inasmuch as the value of garden truck is much greater than standard crops, a farm devoted to truck gardening should produce a crop of much greater value than a farm devoted to general crops.

None of the almshouse farms compare in productivity with the State farms of Massachusetts. The report of these farms for 1911 is given as follows:

VALUE OF PRODUCTS PRODUCED ON THE STATE FARMS IN MASSACHUSETTS, 1911.

	Acres of Tillage	Value Produced During Year	Value Produced per Acre, Excluding Woodland and Pasture
State Hospitals:			
Worcester	175	$59,732.80	$341.33
Taunton	190	30,527.85	160.67
Northampton	210	49,251.36	234.53
Danvers	253	49,313.30	194.91
Westborough	283	48,950.10	172.96
Boston	165	26,849.30	162.71
State Asylums:			
Worcester	321	29,649.86	92.36
Medfield	117	61,372.37	524.55
Gardner State Colony	138	33,191.96	249.56
Miscellaneous:			
Monson	156	36,219.62	232.17
Foxborough	41	14,492.74	353.48
School for Feeble-minded at Waltham	306	47,118.84	153.98
Wrentham School	58	11,296.94	194.77

It will be noted that the Medfield farm produced products to the value of $524; Foxborough farm $353; and Worcester farm $341 per acre. Three other farms produced more than $200 per acre. Each of these institutions has many relatively able-bodied inmates who can do efficient work upon farms. In general they are a stronger class than the almshouse population. To say that the State farms of Massachusetts produce more per acre than the almshouse farms would mean little, owing to the difference in the class of inmates. It is noteworthy, however, that an institutional farm can be made to produce the large value produced by the farms in Massachusetts. It would indicate that the farms of the City's almshouses are not handled in a manner to secure the largest results possible.

New York City Farm Colony, though producing a fair amount of produce per acre, does not approach the amount produced on the State farms in Massachusetts, and does not show an increased production according to the increase in the number of inmates in the institution. The following table shows the record of the institution since 1902, giving the number of employees, number of inmates, and the value of the products of the farm.

NEW YORK CITY FARM COLONY FARM PRODUCTS.

Year	Employees	Dependents	Value of Crops	Expenses	Profit	Gross Profit per Dependent	Net Profit per Dependent
1902	9	115	$4,571.50	$1,268.44	$3,303.06	$39.75	$28.72
1903	12	159	5,410.40	1,280.56	4,129.84	34.03	25.97
1904	11	185	12,676.52	2,361.79	10,314.73	68.52	55.76
1905	20	305	14,294.53	4,008.50	10,286.03	46.87	33.72
1906	30	268	9,513.33	3,504.04	6,009.29	35.50	22.42
1907	38	272	13,857.57	3,704.68	10,152.89	50.94	37.32
1908	35	313	7,583.08	1,244.01	6,339.07	24.22	20.25
1909	40	331	10,602.93	6,380.32	4,222.61	32.03	12.76
1910	42	413	8,925.32	.....	.....	.....	.....
1911	58	703	11,768.72	6,610.78	5,157.94	16.74	7.33

It will be noticed by reviewing the above table that in 1904, with 11 employees and 185 inmates, Farm Colony produced crops to the value of $12,676. In 1911, with 58 employees and 703 inmates, the value of the

products was $11,768. The value will naturally fluctuate from year to year, but it is evident that the gross value produced at the present time is not greater than when the employees and the inmates numbered much less. It will be observed, moreover, that the expense of operating the Farm has increased, leaving a much smaller net profit from the produce.

The farm operated by Manhattan State Hospital, on Ward's Island, may fairly be contrasted with the farm at Farm Colony. Both are within the City limits, and both devote practically their entire area to truck gardening. Farm Colony uses 70 acres for this purpose, and the State Hospital 63 acres. The Hospital employs in cultivating its gardens an average of about 80 men. In 1911 the value of the produce at Farm Colony was $11,768, while that at Ward's Island, with 7 acres less, was $25,870. The unit values of produce used by the State Hospital were less than those used by Farm Colony. Had Farm Colony used the State unit values its total product for 1911 would have amounted to but $8,051.00. Thus it will be observed that the State Hospital farm produced over three times as much as Farm Colony. The contrast in the amount of produce on the two farms is marked.

The farm on Ward's Island is under the supervision of the State Department of Agriculture, whose agents periodically make visits and offer suggestions. The farm at Farm Colony is not under such supervision, which may in a measure account for the difference. It would, therefore, seem advisable for the Department of Charities to avail itself of the advice of the Department of Agriculture. Though the physical condition of the best almshouse population is not equal to that of the insane in the State Hospital, yet the strongest of the male inmates are able to do considerable hard labor, and if only the relatively able-bodied were sent to Farm Colony, and these in a sufficient number, the Colony farm could be made to produce nearly or quite as much as the farm connected with the State Hospital on Ward's Island.

Dr. Williams has shown, as a result of his physical examination of inmates, that about 60 per cent. of the total population is able to do some work. Sixty per cent. of the total population of approximately 5,000 would be 3,000. Assuming that 1,000 of those able to work should be sent to Farm Colony, and that 800 would be employed in helping to care for and maintain the Homes on Blackwell's Island and in Brooklyn, there would yet remain 1,200 who could do some form of light industrial work. These people at the present time are unemployed, and are less happy than if they were occupied. It would seem highly advisable to install in suitable buildings at the three Homes machinery and devices which could be operated by these inmates. The kind of light work now being done, such as broom, mattress, and rug making, could well be enlarged and extended, and, in addition, the inmates could operate simple knitting machines for the production of stockings, sweaters, caps, mittens, etc.; looms for the weaving of coarse cloth, from which clothing could be made; printing presses for the printing of forms to be used in the institutions and other City Departments; bookbinding devices; shoemaking and repairing machinery and tools; and such other devices and forms of labor as may be found on experiment suitable for the class of inmates in our City Homes. The cost of such machinery and devices would not be great. Though the product would not be sold in the open markets, it could be used to advantage in the institutions and other City Departments, and its value would probably more than offset the cost of machinery, buildings, and instructors to supervise the work.

Section VII.—CARE OF OUT-PATIENTS

1. The Out-Patient Department of Gouverneur Hospital
2. Suggestions for the Organization of a Public Out-Patient Department
3. Sickness in the Home and Proposed Health Center

1. THE OUT-PATIENT DEPARTMENT OF GOUVERNEUR HOSPITAL

THE INVESTIGATION

The Importance of the Dispensary

A house-to-house canvass of certain districts of the City to discover conditions of sickness revealed the fact that there is a very great amount of preventable sickness that receives either no medical attention, or inadequate medical care. (The results of this canvass are set forth on pages 519 to 534.) Occurring in homes where ignorance, poverty, or other conditions make a proper treatment of the sickness impossible, the diseases are rendered fatal, or protracted beyond their normal period, or become centers of contagion for the community.

The most effective instrument for reaching and alleviating these conditions is the public dispensary. It was found that while the people were disinclined, for various reasons, to seek relief at the hospitals, they were anxious to utilize the dispensaries, but were deterred by the conditions existing in these institutions. In the large majority of cases one visit to the dispensary made them dissatisfied with the treatment and unwilling to return. Either the attitude assumed toward them was harsh and unsympathetic, the examination was superficial, or some other circumstance arose to arouse mistrust. Whatever the real value of the dispensary is, it is very evident at present that its efficiency is somewhat distrusted by just those people whom it should reach.

Such an attitude is exceedingly harmful, and any reorganization that would tend to restore public confidence in the out-patient department is much to be desired. This particular investigation was undertaken to determine the present effectiveness of the public dispensaries, and to discover means for increasing the scope and improving the character of their work.

Conditions in Gouverneur Hospital

Certain features of Gouverneur Hospital Out-Patient Department led to its selection for investigation: (1) the large number (an average of 465 daily) of patients; (2) the character of patients—conditions of poverty, ignorance, etc.; (3) living conditions in the section from which it draws its patients—congestion, etc. Such conditions would seem to render necessary the highest character of work in an out-patient department—preventive and educational work. The opportunities for recognizing and checking contagious diseases and other debilitating sickness in an incipient stage are numerous in this section, but that such results are not accomplished will appear from the following facts.

In all the clinics of Gouverneur Hospital that were studied—the Children's; the Gynecological; the General Medical; the Skin; and the Ear, Nose and Throat—it was found that the work in general is hasty and unsatisfactory. There are seven clinic rooms in all, and in them are performed the functions of eleven clinics on Mondays, Wednesdays, and Fridays, and eight on Tuesdays, Thursdays, and Saturdays. On these former days, therefore, each room must do double or triple duty, in most cases

with only a few minutes' intermission, so that thorough cleansing is impossible, and the waste material and odors remain from one clinic to the other.

Of the 63 doctors and surgeons who comprise the medical staff of the Out-Patient Department, 29, or 46 per cent., have their private offices located in the neighborhood of Gouverneur Hospital. The patients whom they treat privately are drawn, in the main, from the same district as the dispensary patients.

Our investigators heard two of the doctors speak abusively to several women for coming to the dispensary instead of going to the doctors' offices. One woman who brought a very sick child to the clinic was harshly ordered out of the room because she wore earrings, the doctor declaring that, "people who wear diamond earrings can afford to go to a private doctor." The woman was deeply hurt by the repulse, and told our investigator that the earrings were a wedding present from her husband, and that she had worn them for over twenty years; they were not worth more than two dollars, she said. Her husband was striking at this time, and she did not have enough money to secure food for the family. She left Gouverneur to seek entrance at another dispensary, the child being seriously ill. The doctors often refuse treatment to patients, thus assuming a function that should properly be left to administrative routine. Many patients, 4 per cent. of all those investigated, have gained the impression that the doctors harbor a feeling of resentment against them for not patronizing the private offices.

Many patients were admitted to the clinic rooms at the same time. On some occasions a room was so crowded that the doctor had to force his way through the standing patients, examining and prescribing. One of our investigators sat in the room being used as a Female General Medical Clinic from 10:30 to 12 A. M., on March 15, 1913, and saw 162 patients treated during that time by two doctors, an average of 1 minute and 6 seconds for each patient. Of these, 105 were new patients, of whom it was necessary to obtain a history of symptoms, etc., before prescribing. In the room used as a Children's Clinic (149 square feet), at the same period, another investigator counted 36 patients at one time. In this group one diphtheria and two scarlet fever cases mingled with the other children for over thirty minutes.

In the majority of cases, as will subsequently be shown, there was either no physical examination before prescribing, or when it was made it was so superficial as to be almost valueless. The doctor moved from patient to patient, with a pencil and pad of paper in his hands, asking a few stereotyped questions and dispensing prescriptions as rapidly as he could write them. The results, as will appear, were that most patients received little or no relief from their ailments, and there were frequent wrong diagnoses, with a possibility of disastrous effect.

There is a distinct danger, also, in such a heterogeneous crowding of sick persons. The transmission of diseases through contact is made probable, especially in the Children's Clinics, where contagious diseases are common.

This danger of contagion is rendered more active by conditions in the waiting-room. This room, containing 1,300 square feet (the area of which is decreased by the fixtures of 25 benches, 6 x 1½ feet each), often holds over 200 persons at one time. In such a crowd, on March 11, 1913, one of our investigators observed two children, Molly S——, 3 years old, of No.

—— Cherry Street, and Annie M——, 3½ years old, of No. —— Monroe Street, waiting 45 minutes. The diagnosis for both was scarlet fever. During the time they waited for examination these children mingled freely with others, and even after the doctor had discovered the disease it was 15 minutes before they were taken from the crowded room. There was nothing to prevent this from becoming a common occurrence.

All cases of measles, whooping-cough, scarlet fever, and diphtheria are dismissed with the order not to return. In the case of the last two ailments, postal-card notices, such as are used by private physicians, are sent to the Department of Health. If the address given is false or otherwise incorrect, as very often happens, the patient is never reached by the Health Department Inspectors and remains without any supervision, a danger to the community. While the form of notice which is sent to the Department is the same as that used by physicians in their regular practice, it is made somewhat distinctive by the addition of the name of the Hospital by means of a rubber stamp.

There is on record in the Gouverneur Out-Patient Department, under date of January 8, 1913, the following case:

Chas. G——, aged 7 years, of No. —— Cherry Street, which was diagnosed as variola (smallpox) and sent home without any precaution against contagion except the formal notice to the Health Department. An Inspector from the Health Department visited this case the following day and found that the Gouverneur physician had made a wrong diagnosis, the case being one of chickenpox, and not smallpox. If it really had been the latter, however, the extremely negligent handling of the case by the Gouverneur officials would have resulted in serious danger to the community. In the first place, the boy mingled with the other children during the time before and after examination, and when he left the clinic there was nothing to prevent him from coming in contact with many persons on his way home, or from spreading the disease among the other members of the family and in the tenement during the time that elapsed before the Health Department Inspector came. In the second place, the address given might have been false, a very common occurrence, so that the case would not have been reached by the Health Department until smallpox had become epidemic in the neighborhood.

That the Gouverneur Out-Patient Department method of handling contagious and communicable diseases probably results in an increased number of cases is shown by the following facts:

Of 40 cases of contagious and communicable diseases (5 diphtheria, 7 scarlet fever, 6 chickenpox, 11 whooping-cough, and 11 measles) that came to the Gouverneur Out-Patient Department during January, 1913, and were dismissed with the direction: "Do not come back here—go to a doctor," it was found upon investigation at the homes that, in 6 of the whooping-cough cases no private doctor was called, and the children were sick for a period of 6 to 10 weeks each, without any medical attention, and in two instances the disease was contracted by other members of the family and by other families in adjoining flats. In 3 of these, and in 3 measles, 2 scarlet fever and 2 diphtheria cases, the addresses given were incorrect, so that the Health Department was unable to reach them for quarantine or fumigation. What amount of contagion was spread by these unsupervised cases cannot be determined. No private doctor was called for any of the chickenpox cases, and in two instances the disease was communicated to other families in the same tenement.

The measles cases were neglected in the same manner. In 3 of the cases that could be reached by our investigators doctors were called in, and in the other 5 no medical treatment was received.

Many complaints are made about the pharmacy. There is a great deal of delay; patients stand in line sometimes from 1 to 2 hours; and in addition, the patients state that mistakes are frequently made in compounding prescriptions. The following case, supported by affidavit, is quoted as typical of the complaints made:

Case No. 117. P. M——, boy, 3 years old, No. — Monroe Street. Taken to Gouverneur O. P. D. by father January 4, 1913; doctor examined him and gave prescription (diagnosis on register: asthma). Father had prescription filled at the pharmacy window and went home. Immediately after taking a teaspoonful of the medicine according to directions the child complained of being burned by the liquid and became unconscious. The father seized the bottle of medicine and ran to the Dispensary. When he told the porter what had occurred the bottle was snatched from him and he was told that a doctor would be sent to the house at once. When he requested to have the bottle returned to him, it was refused. A Gouverneur ambulance arrived at his home simultaneously with himself and the ambulance surgeon administered an emetic which caused the child to vomit. After an hour of constant work on the part of the doctor the child revived. The father refused to permit the child to be taken to Gouverneur Hospital as the doctor wished and has since had him under the care of a private physician. The diagnosis for this ambulance case is given in the ambulance record as asthma.

Aside from the mere lack of space in the general waiting room the arrangement is least economical for every purpose. One door is used for entrance and exit. Moreover, the drug dispensing window is adjacent to this same door, so that there is a continual thronging about this section of the room, while many must wait outside until place is made indoors. Our investigator counted 64 people in line, reaching from the entrance on Water Street around the corner to the front of the door. It was raining hard on this morning (March 15, 1913) and these sick persons stood from 15 to 30 minutes waiting for the line to move on, while, at the same time, there was sufficient room for them inside if proper rearrangement had been made.

When the patient has entered he must pass through the crowd of people to the middle of the room where the admitting desk is located. Because the seats are not arranged with regard to the crowded condition many patients must stand until they are admitted for treatment, and then continue to stand for a more or less lengthy period until the prescriptions are filled. These crowds make it impossible for the admitting clerk to see that everyone first passes by his desk, and the attention paid to records in the clinic rooms is so lax that it is easily possible for patients to enter clinic rooms without having been to the admitting desk. The records kept by the admitting clerk consist merely of cards representing the different clinics, and a book in which the totals of new and old patients are entered each day.

The records of cases treated are kept in books and, with the exception of the Gynecological and the Tuberculosis Clinics, the only information secured is the name, age, address, and diagnosis of the patient. From these records it is impossible to determine whether or not the patient ever returned for additional treatment. In one of the Children's Clinics, and in the Nose, Throat and Ear Clinic a nurse and a general clerk enter the names, etc., while in the other clinics the doctors themselves make the entries. Whenever a very busy period occurs the records are neglected, so that there is hardly ever a complete recording of patients handled. As they stand the records are very deficient, since they give no information as to

the kind of treatment prescribed or the result of such treatment; and it is, therefore, impossible to determine from them whether or not the patients are being cured by the Dispensary. Our investigation, in the main, was an attempt to satisfactorily answer this last question—the efficiency of the Out-Patient Department.

Efficiency of Service

Table I shows the total and average number of visits per patient in each clinic during 1912. In most of the clinics the average is very low, and this would seem to indicate that a great number of cases came for the initial visit, and for various reasons failed to return for additional treatment. Such averages as 1.7 visits per patient in the Nose, Ear and Throat Clinic; 2.1 in the Skin; 2.3 in the General Medical; and 3.7 in the Gynecological, are extremely low, since these clinics handle cases that can only be benefited by continued treatment. The following table shows how these figures compare with those from the St. Bartholomew Clinic of New York:

Clinics	Average Number of Visits per Patient	
	Gouverneur	St. Bartholomew
General Medical	2.3	3.7
Gynecological	3.7	6.8
General Surgical	2.3	5.3
Genito-urinary	6.7	5.5
Rectal	...	14.3
Eye	2.3	3.3
Ear	...	6.7
Nose and Throat	*1.7	4.2

* Ear, Nose and Throat are in one clinic in Gouverneur Hospital.

This feature, and others equally serious, were shown more clearly in the group of cases investigated by the inspectors from this Committee. (Table II, on page 468.)

One thousand cases that came to Gouverneur during the first two weeks in January, 1913, were investigated. Because of unavoidable duplication this number was later reduced to 976. These 976 cases consisted of 499 from the Children's Clinics (the first 499 in order); 217 from the Adult General Medical; 160 from the Nose, Ear and Throat; and 100 from the Gynecological Clinic. Every one of these patients was visited at the address given in the Gouverneur books and information gathered regarding the home and financial conditions; number of visits to Gouverneur Out-Patient Department; result of treatment and subsequent disposition of the case. In 459 cases, 47 per cent. of all, the patient could not be found at the address given, because it was false (that is, no such number on the street) or otherwise incorrect.

Of the 517 cases that were reached (Table II), it was found that 272, or 52.6 per cent., made only one visit to Gouverneur. Of these, 121, or 44.5 per cent., were benefited or cured by the treatment, and 151, or 55.5 per cent., were not benefited. One or more reasons accounted for the failure to return in each of these 151 cases: 11, or 4 per cent., declared themselves

to have been abused or injured by the officials; 85, or 31.3 per cent., were dissatisfied with the character, or lack, of examination, and being unwilling to trust to the opinion of the Gouverneur doctors, went to other dispensaries or, in some cases, to private physicians. In 16 cases, or 5.8 per cent., the patients were unable to return because they could not spare the necessary several hours from household duties or other work.

Of the 245, or 47.4 per cent., who made two or more visits, 75, or 30.6 per cent., stated that they had been benefited by the treatment; 33, or 13.4 per cent., said they had been cured; and 137, or 56 per cent., stated that they were not benefited. Of these latter, 63, or 25.6 per cent., went to other dispensaries or to private physicians, and the remaining 74, or 30.2 per cent., were still sick and without any medical attention.

In 20, or 3.8 per cent. of the total number of cases, the patients were referred to hospitals. The patients in 73 cases, or 14.1 per cent., stated that they had not been examined by the attending physicians at the time of their visits to the Out-Patient Department, and had received no benefit from the medicine prescribed.

In 35 cases, or 6.8 per cent., 28 of which were of children, the patients became worse after the visit to the Gouverneur clinics and called in private physicians who, in each case, stated that the illness was different from the diagnosis originally made at Gouverneur.

Many of these wrong diagnoses involved serious cases which might have terminated fatally if additional medical aid had not been secured.

In 171 cases, 33.1 per cent. of all, the conditions in the homes were such that the treatment given by the Out-Patient Department was unavailing. Extremely unsanitary living quarters, which aggravated the sickness; extreme poverty, which prevented the physician's directions from being followed; ignorance of ordinary preventive measures; other cases of disease in the family, some of them communicable, were some of the conditions which point toward the need of a "follow-up" system to insure the efficiency of the Out-Patient work.

The Work of the Children's Clinics

Of the 304 children whose cases were investigated it was stated in 149 instances, or 49 per cent. of all, that no benefit had been received. In 42 cases, or 13.8 per cent., the parents stated that absolutely no physical examination of the children was made, prescriptions being given on the oral description of the cases by the parents. In 92 cases, or 30.3 per cent., the parents or relatives, distrusting the opinion of the clinic physicians, went to other dispensaries or called in the services of private physicians. Twenty-eight cases, or 9.2 per cent. of all, were found by private physicians to have been wrongly diagnosed.

A few of these cases are quoted from the investigators' reports:

Case No. 19. G—— K——, girl, 6 years, No. — Mangin St., complained of sore throat and was taken to Gouverneur Out-Patient Department Jan. 2, 1913. Diagnosis on Gouverneur register, tonsillitis. G—— went home; took medicine as prescribed by Gouverneur physician; became worse. Same afternoon mother called in Dr. X——, who diagnosed the case as diphtheria. Health Department notified and the house was quarantined. G—— was sick with diphtheria six weeks.

Case No. 72. I—— F——, boy, 2 years, No. — Madison St. Taken to Gouverneur Out-Patient Department, Jan. 2, 1913. Diagnosis on register, bronchitis. Mother gave the child medicine as prescribed; did not help him; child became

feverish; mother borrowed money and called in Dr. X——, who diagnosed the case as pneumonia. Dr. X—— treated the child four weeks.

Case No. 422. G—— S——, boy, 2 years, No. — Madison St. Taken to Gouverneur Out-Patient Department Jan. 17, 1913, suffering from pain in chest. Diagnosis on register, bronchitis. Mrs. S—— says the doctor gave G—— very superficial examination. The medicine prescribed did not relieve child and Mrs. S—— called in Dr. X——, who found the patient in high fever from pneumonia. G—— was sick two weeks.

Case No. 361. B—— B——, boy, 11 years, No. — Montgomery St. Had pains in left side of chest. Taken to Gouverneur Out-Patient Department Jan. 13, 1913. Diagnosis on register, bronchitis. B—— grew worse after return from Gouverneur; no relief from medicine. Mother thereupon took him to the Beth Israel Out-Patient Department where he was examined and the disease diagnosed as empyema. He was referred to the hospital where he was successfully operated upon and discharged at the end of three weeks.

Case No. 1187. S—— L——, boy, 14 years, No. — Jackson St. S—— felt feverish and had swollen lips. Taken to Gouverneur Out-Patient Department Jan. 7, 1913. Diagnosis on register, stomatitis. S—— felt more feverish after return from Gouverneur and medicine gave no relief. Dr. Y—— was called in and pronounced it an advanced case of scarlet fever. Health Department was notified and an Inspector came and quarantined the family. S—— was sick eight weeks.

In 42 cases, 13.8 per cent. of all, the parents stated that the children were not examined by the physicians of the clinic, the parents having been merely asked about the condition of each child and a prescription given.

There were 97 cases, 31.9 per cent. of all, where the investigators found conditions in the homes that would militate against the efficiency of any treatment that the dispensary could give. There were cases that could not return for additional treatment because of weakness, or lack of time on the part of the parents; extremely unsanitary conditions that aggravated the disease; extreme poverty or ignorance, so that the directions of the physician were not followed; other cases of disease and consequent danger of infection; and similar unfavorable conditions.

The Work of the Adult General Medical Clinics

Of the 93 cases that were reached by our investigators, 32, or 34.4 per cent., stated that they had been benefited or cured by the treatment, and 61, or 65.6 per cent., were not benefited. They reported as reasons therefor, lack of proper examination and inefficiency of treatment. Of these 61, 29 did not return to the Out-Patient Department after the first visit; 10, or 24 per cent., having gone to private physicians, and 6, or 13.4 per cent., to other dispensaries, and the other 13 were still sick and without any medical attention. Of the 32, or 62.8 per cent., of those who made two or more visits to Gouverneur and were not benefited, 15, or 29.4 per cent., went to other dispensaries, and the other 13 were still sick and without any medi-
sick and without any medical attention.

In 21 cases, or 22.6 per cent. of all, the patients reported no physical examination at first or subsequent visits, the diagnosis and prescription having been based on the patient's response to the question: "What's the matter with you?"

The home conditions in 27 cases, 28.8 per cent. of all, were found to be such as would interfere with the effectiveness of the treatment at the Out-Patient Department. Severe illness; household duties, or other work, that made it impossible to continue the visits to the dispensary; unsanitary surroundings that aggravated the sickness, particularly in lung and throat diseases; infection and other diseases existing in the same rooms with the patient; etc., were some of the unfavorable conditions that were found.

The Nose, Throat, and Ear Clinic

Of the 77 cases that were reached by our investigators, 41, or 53.2 per cent., did not return after the first visit. Of these, 14, or 34.1 per cent., stated that they had been benefited or cured by the treatment, and 27, or 65.9 per cent., had not been benefited. Of these, 12 had gone to other dispensaries or to private practitioners, and 15 were still unwell and without any medical treatment, and unable or unwilling to return to Gouverneur. Of those who had made two or more visits, 21, or 58.4 per cent., stated that they had been benefited or cured by the treatment, and 15, or 41.7 per cent., had not been benefited. Of these, 4, or 11.1 per cent., went to other dispensaries, and the other 11 were still unwell and without any medical attention.

There were 33 cases, or 42.9 per cent. of all, in which the occupation of the patients or their home conditions were such as to seriously interfere with the efficiency of the clinic treatment.

The Gynecological Clinic

Of the 43 cases from this Clinic that were investigated 17, or 39.5 per cent., made only one visit to the Clinic. Of these, 4, or 23.5 per cent., stated that they had been benefited or cured by the treatment, and 13, or 76.5 per cent., had not been benefited. The percentage of cases that had made repeated visits and stated that they had not been benefited was still greater—88.5 per cent. of all the cases.

Comparatively, there were more complaints against this Clinic than any of the others. Superficial physical examination and carelessness were declared to be the reasons for the lack of benefit from the treatment; in 7, or 16.3 per cent., of the cases absolutely no physical examination of the patient was made.

TABLE I.

PATIENTS TREATED AT GOUVERNEUR OUT-PATIENT DEPARTMENT, 1912.

Date	General Medical		Gyne-cological		Skin		Tuber-culosis		Ear, Nose and Throat		Stomach		Eyes		Genito-urinary		Surgical		Total New Cases	Total No. of Visits
	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits	No. of Cases	No. of Visits		
January	2,124	4,189	89	223	464	861	26	288	493	820	85	204	195	471	37	188	1,204	2,732	4,717	9,976
February	2,229	4,800	59	203	441	918	23	280	445	766	13	102	213	500	24	154	1,091	2,776	4,538	10,499
March	2,125	4,820	59	208	489	966	30	231	500	830	18	90	174	286	20	196	1,178	3,085	4,593	10,712
April	2,390	5,454	66	257	511	1,109	36	287	580	962	16	100	128	263	35	223	1,321	3,277	5,083	11,952
May	2,716	6,256	76	300	470	1,011	48	349	566	964	12	112	239	488	26	204	1,421	3,546	5,574	13,230
June	3,806	6,956	68	330	550	1,020	41	365	565	996	33	118	218	565	15	172	1,506	3,581	6,802	14,103
July	3,150	6,969	94	350	517	1,105	26	211	488	832	5	70	170	314	37	211	1,720	3,828	6,207	13,890
August	3,060	7,035	115	366	538	1,259	37	312	500	860	1	38	224	415	50	181	1,503	3,236	6,028	13,702
September	1,956	4,457	59	231	366	806	24	229	344	598	3	43	139	285	22	172	1,203	2,533	4,116	9,354
October	2,508	5,776	82	337	423	854	22	272	481	827	5	52	158	321	11	150	1,117	2,696	4,897	11,285
November	1,804	4,829	84	290	365	933	25	286	424	797	16	85	150	297	26	195	1,065	2,927	3,959	10,639
December	1,774	4,548	43	240	379	989	30	333	490	885	8	72	90	183	27	179	1,082	2,644	3,923	10,073
TOTALS	29,732	66,089	894	3,335	5,513	11,831	368	3,443	5,876	10,157	215	1,086	2,098	4,388	330	2,225	15,411	36,861	60,437	139,415
Average number of visits per case	2.3		3.7		2.1		9.4		1.7		4.9		2.3		6.7		2.3		2.3	
Percentage of total attendance		47.4%		2.4%		8.4%		2.5%		7.3%		.7%		3.1%		1.6%		26.6%		100.0%

TABLE II.

Findings of Field Investigation

With Regard to Patients Having Attended Gouverneur Out-Patient Department during the First Two Weeks of January, 1913.

Clinics	Cases Investigated	Cases Making 1 Visit	Cases Making 2 or More Visits	Results of Treatment in Cases Making 1 Visit						Results of Treatment in Cases Making 2 or More Visits					Not Examined by Doctor	Wrong Diagnosis	Referred to Hospital	Social Service Needed
				Cases Benefited or Cured	Cases Not Benefited	Findings in Some of the Cases Not Benefited.				Cases Benefited	Cases Cured	Cases Not Benefited	Findings in Some of the Cases Not Benefited					
						Unsatisfactory Treatment	Unable to Return	Went to Private Physician	Went to Other Dispensary				Went to Pri-vate Physic'n	Went to Other Dispensary				
Children's	304	172	132	90	82	8	7	33	19	44	21	67	28	12	42	28	4	97
General Medical	93	42	51	13	29	1	4	10	6	14	5	32	8	7	21	3	3	27
Gynecological	43	17	26	4	13	1	3	3	2	3	0	23	2	2	7	2	6	14
Nose, Throat and Ear	77	41	36	14	27	1	2	8	4	14	7	15	0	4	3	2	7	33
Total	517	272	245	121	151	11	16	54	31	75	33	137	38	25	73	35	20	171
								Expressed in Percentages.										
Children's	304	56.6	43.4	52.3	47.7	4.6	4.1	19.1	11.0	33.3	16.0	50.7	21.1	9.1	13.8	9.2	1.3	31.9
General Medical	93	45.2	54.8	30.9	69.1	2.4	9.6	24.0	13.4	27.4	9.8	62.8	15.7	13.7	22.6	3.2	3.2	28.8
Gynecological	43	39.5	60.5	23.5	76.5	5.9	17.7	17.7	11.8	11.5	0.0	88.5	7.7	7.7	16.3	4.6	13.2	32.6
Nose, Throat and Ear	77	53.2	46.8	34.1	65.9	2.5	4.9	19.6	9.8	38.9	19.4	41.7	0.0	11.1	3.9	2.6	9.1	42.9
Total	517	52.6	47.4	44.5	55.5	4.0	5.8	19.9	11.4	30.6	13.4	56.0	15.4	10.2	14.1	6.8	3.8	33.1

Note: Cases classified as benefited or cured are based upon the personal statement of each patient.

2. SUGGESTIONS FOR THE ORGANIZATION OF A PUBLIC OUT-PATIENT DEPARTMENT

FOREWORD

The findings of fact in connection with the investigation of the present dispensary of Gouverneur Hospital disclose a great deal of wasted effort and inefficient treatment of patients, and the conclusion is reached that a reorganization of the dispensary is necessary to secure satisfactory results. In this section an effort has been made to give definite scope to this general conclusion. The time and means at our disposal have not permitted us to go into details of organization and management as thoroughly as desired. Several of the leading dispensaries in New York, Boston, and other cities have been visited; their facilities and system of operation studied; literature on the subject has been examined; and conferences have been held with a number of the leading experts in dispensary work, and their criticisms invited. Much valuable information has thus been secured. It has not been possible to formulate definite rules in all cases, as dispensary practice has by no means been standardized; neither has it been the aim to go into the refinements and technical details connected with the operation and management of a large dispensary and suggest improvements. An earnest effort has been made to merely outline a general plan of organization, following what seems to be the best practice prevailing at present in the leading dispensaries, with due reference to conditions in the public out-patient departments of New York City.

THE OUT-PATIENT DEPARTMENT AS AN AGENCY IN THE CARE OF THE SICK

The Beginning of Dispensary Work

The out-patient department as a branch of the New York public hospital service was first established at Bellevue Hospital in 1866, after the matter had been taken under consideration by the Commissioners of Public Charities and Correction in 1864. At that time it seemed necessary to make additions to the hospital service, and the Commissioners thought that the establishment of an out-patient department would relieve the Hospital from the treatment of a large number of patients who might be treated successfully in such a department. The Commissioners also thought that many people who suffered from diseases which did not prevent them from pursuing their usual vocations, but who were unable to pay for the services of skilled physicians and specialists, or for expensive medicines, would avail themselves of this mode of relief. The successful operation of such a system in Paris and London was another important factor in bringing this new department into existence at Bellevue Hospital.

The Bureau of Medical and Surgical Relief for the Out-Door Poor (the original name of the Out-Patient Department) was opened on October 15, 1866. The medical organization of this Bureau was not far different from the ordinary out-patient department of to-day. It consisted of twenty consulting physicians and surgeons. The cases treated were classified as follows: Diseases of the chest; diseases of women and of children; orthopedic and general surgery; and nervous, urinary, skin, eye and ear diseases. In these various clinics, from the date of opening to the following January, 437 patients were treated and 1,378 prescriptions were issued. In the second year of operation the attendance increased over 15,000 patients, justifying the step taken by the Commissioners to fill a particular medical need in the community.

The other City hospitals were gradually provided with out-patient departments, and, meanwhile, private institutions established similar departments, generally of the same kind as the City's. The earliest, probably, was that of the New York Hospital in 1875.

The Present Status of the Dispensary

The work in connection with the out-patient department, though at first quite simple, has become more and more complex. Organized in the beginning to give medical relief to the sick poor who applied at the dispensary, and who were not deemed in need of hospital care, it has developed

many new phases in different institutions. Its scope has gradually been extended by the addition of other clinics; and by sending physicians and nurses to treat sick people in their homes, to give instructions for their care, and to ascertain the causes of disease due to environment or social conditions. It has become educational through dissemination of information regarding the nature of sickness and the means of combating it; instructions to mothers in pre-partum hygienic measures and the proper methods of caring for infants, and other measures; and it is aiming at prevention, by the treatment of incipient cases which might otherwise develop into serious illnesses, and by the segregation of certain infectious cases of disease.

These and other functions are not all performed by any one out-patient department. Special phases of the work have been carried further in some institutions than in others, but there is a strong tendency on the part of those in charge of dispensary work to adopt those methods of controlling disease which have justified themselves by results. It is held that treatment to be effective must be complete; that is, the underlying social and environmental causes of disease and its after effects must be considered, as well as the specific illness itself.

Along with the widening of the scope of dispensary work there has been a steady increase in attendance. It has recently been stated by Mr. Michael M. Davis, Director of the Boston Dispensary, that fully three million persons, mostly in large cities of this country, receive treatment annually in the out-patient departments or dispensaries. How many treatments these represent can only be estimated. In the annual report of the State Board of Charities for 1910 the number of persons treated in the licensed dispensaries of this State was given as 1,156,701. Of this number 1,123,457 were credited to New York City. The total number of treatments for the State was given as 3,546,729, of which 3,415,741 were credited to New York City. In the 1911 report of this Board the total treatments for the State were given as 2,426,607, of which 818,618 were new cases. This smaller number of treatments, as compared with 1910, is apparently due to the fact that in 1911 returns were not included from dispensaries which did not receive public money for support. Many dispensaries in this City treat from 30,000 to 60,000 patients per year, representing from 100,000 to 160,000 treatments or more. Even if only approximately correct, allowing for duplications and other errors, these figures clearly indicate the important place which the dispensary has come to occupy in the treatment of disease, especially in New York City, and from the point of view of public health, as well as from that of the individual patient, it is of vast consequence that dispensaries should be well organized and the work well done.

Notwithstanding this extensive and important work the dispensary has received very inadequate appropriation and support. This may be due in part to the fact that the physicians, who generally give their services free, have not considered the dispensary patient as interesting material from the clinical standpoint, and many of the best men, therefore, have declined appointment on the dispensary staff, or have not attended the clinics regularly, leaving much of the work in the hands of inexperienced or incompetent men. A more important reason may be sought in the attitude of responsible authorities, who have failed to comprehend the importance of dispensary work, its possibility, and its true social function, and have, therefore, given to it scant consideration and support.

The inevitable result of treating such a large number of patients with

inadequate facilities and equipment, and with inadequate organization, has been that a great deal of very inferior—not to say criminally careless—work has been done. The investigation into the work of the present out-patient department of Gouverneur Hospital (see another section of this Report, page 468) showed that from 49 per cent. to 76 per cent. of the cases that required additional treatment did not return after the first visit, and that from 50 per cent. to 88 per cent. of the cases that made repeated visits had not been benefited. While it is not to be assumed that all the patients who come to the dispensary can be cured or even benefited, the facts disclosed by this investigation can lead only to the conclusion that a large percentage of the present expenditure for out-patient work in that Hospital is entirely wasted, or worse. The other feature, namely, the loss to the community through sickness and general disability that might have been prevented or alleviated by an efficient out-patient department, cannot be so readily estimated, but is of still greater importance.

The ineffectiveness of the work of the Gouverneur Out-Patient Department, as disclosed by the part of the Report referred to, is due largely to faulty organization and inadequate facilities. Much of the present waste of money and effort can be avoided, and should be. For this purpose there are set forth below certain principles and practices to guide the City in the conduct and arrangement of its dispensaries. It is believed that they represent the best practice of the present day, and, while not ideal, they will serve as a basis for future development.

The Function of the Out-Patient Department

The chief agencies for the care of sick people are: (1) the hospital; (2) the dispensary or out-patient department; and (3) district or home nursing. The function of the hospital is well understood; namely, the treatment of serious cases of illness or injury—a treatment afforded to a comparatively small number of people at a relatively high cost by the best means known to medical and surgical science. The district or visiting nurse undertakes, usually under the direction of the family or other physician, such services as may be needed by sick patients in their homes, who are not in need of hospital care, or who are unwilling or unable to go to a hospital for treatment. Between these two agencies the dispensary occupies an intermediary position.

The function of the dispensary is described by Mr. Michael M. Davis, in the *Boston Dispensary Quarterly* for July, 1913, as follows:

> The special field of the out-patient department or dispensary includes, of course, the minor surgical accidents; but besides these, and in great number, come the incipient cases of illness; the chronic diseases which daily wear upon the efficiency of the workingman or the burdened mother; the minor illnesses which will become progressively more serious if neglected; the developmental defects of childhood, whose correction is cheap and easy if taken in time, but expensive or perhaps impossible if deferred. Acute and serious sickness also appears in the out-patient clinic, calling often for reference of the patient to a hospital or to the care of a physician in bed at home.

The above statement applies mainly to minor illnesses and injuries suffered by poor people who cannot afford to engage a private physician, but Mr. Davis calls attention to the fact that the advance in medicine in recent times has created a host of specialists for the treatment of special diseases, such as diseases of the eye, of the nose and throat, diseases of women and children, and many others. The services of these specialists on a paid

basis, he asserts, are beyond the reach of most persons except the well-to-do. The dispensary appears to be the only agency which, by proper organization and facilities, can render the services of these experts available to certain classes of the population who would otherwise have to do without such help. The dispensary, therefore, does not solely concern itself with the care and treatment of the very poor.

The dispensary thus touches the work of the hospital on one hand, and on the other joins with the district nurse in alleviating distress and sickness in the home, but over and beyond this there is a wide field for the dispensary to occupy in the prevention of disease by various educational measures. Modern medicine wisely lays emphasis on prevention rather than cure. The roots of many cases of individual illness are to be found in social and industrial conditions over which the individual has little or no control. Many injuries from the use of unguarded machinery are obvious cases of this kind. It is not so evident, but nevertheless true, that crowded conditions, unsanitary plumbing, and bad ventilation in the factory and workshop, as well as in the homes of the poor, are predisposing causes which tend to undermine the health and strength of the worker. This condition of impaired health brought about by these causes is aggravated by poverty, in turn due, in some measure, to seasonal employment, and other social and industrial maladjustments. Ignorance of personal and family hygiene, bad food, and worse cooking, shiftlessness and faulty habits, serve to complete the general breakdown. The crisis cannot be met by the slender resources of the individual, who is forced to seek aid or go without proper care and treatment, and, sooner or later, is sure to become a burden on the community.

The City has already assumed the function of caring in part for cases of sickness arising from these factors, because of the great danger and loss to the community—not only from contagious diseases, but from social inefficiency—of large numbers of its people. The City maintains large and well-equipped hospitals for this purpose, and any agency which promises effective assistance in combating the evils of sickness and consequent dependency should receive adequate support. A comparison of hospital and dispensary cases is instructive.

In Bellevue and Allied Hospitals 57,422 cases were treated in 1912, with a total of 650,154 days of treatment. In the out-patient departments of these hospitals 153,005 patients were treated during the same year, with a total of 418,900 visits. The dispensary patients, therefore, outnumber the hospital patients about three to one. In Gouverneur Hospital alone 4,930 patients were treated during 1912, with 64,204 days of treatment. In the out-patient department of that hospital 60,036 patients were treated, with a total of 138,432 visits; that is, the number of dispensary patients was more than twelve times the number of hospital patients, and the number of dispensary visits was more than twice the number of days of treatment in the Hospital. The cost of treatment for one day in these hospitals is given as about two dollars, and the cost of a dispensary visit about ten cents.

It must not be assumed that all hospital cases are serious cases, requiring prolonged treatment. Of those admitted to Bellevue Hospital, 3,884 were patients in the psychopathic ward, most of whom were discharged after a few days' observation to a hospital for the insane. There were also admitted 8,860 alcoholics, and of these, 55 per cent. remained less than 5 days. A study of other cases discharged from Bellevue Hospital during 1912 as "cured" or "improved" showed that a large number of the cases

remained for a very short time only, and very probably were not true hospital cases. Of 5,159 patients who left the medical service with the authorization of the house physician as having been "cured" or "improved," 65 were discharged on the day of admission; 394 on the day following admission; and 461 on the third day. In other words, 920 patients, or 17.1 per cent. of all discharges from this service, were in the Hospital 3 days or less from the day of admission. Of 6,269 patients who were discharged from the surgical service as having been cured or improved, 151 were discharged on the day of admission; 741 were discharged on the day following; and 522 left on the third day. That is, 1,414 patients, or 22.5 per cent. of all of the discharged, were in the Hospital for 3 days or less. In the gynecological service the average length of stay is somewhat greater, but here, also, there was a considerable amount of short period discharges. Of 1,476 patients discharged as "cured" or "improved," 8 were discharged on the day of admission; 128 on the following day; and 70 on the third day. Two hundred and sixteen, or 14 per cent. of all the discharges, were within 3 days of the date of admission. In the genito-urinary service 30.3 per cent. of all of the discharges were in the Hospital 3 days or less. According to the records, 45 were "cured" or "improved" on the day of admission; 370 on the day following admission; and 200 on the third day.

These facts serve to show the advantage of a close coördination between the out-patient department and the hospital with which it is affiliated. Doubtless many of these short time patients, requiring treatment for a brief period, or observation to determine diagnosis, were proper hospital cases, but it seems quite obvious that many of them were not—genito-urinary and gynecological cases serious enough to require admission to a hospital can hardly be cured within 3 days from the date of admission, and certainly not within a few hours. A close coördination of the hospital with an out-patient department organized to treat patients of this kind would relieve the hospital from the necessity of handling many of these cases. In addition, there are many patients now being discharged before their condition really warrants it, in order to make room for more urgent cases. The discharge of such patients could be properly made if they could be transferred to an out-patient department for supervision and occasional treatment and advice during the period of convalescence. A closer correlation of the work of the hospital and dispensary would enable the hospital to treat a larger number of more serious cases, and it would be much more economical for the City, as a day's treatment in a hospital costs about two dollars, and adequate treatment in a dispensary can be furnished for about one-tenth of that amount per visit. There has been some coöperation between the hospital and dispensary in the past, but it has not been developed so far as it should be. Suggestions along this line are made in the pages on "Organization."

The enormous attendance at many of our leading dispensaries has frequently been cited as proof of the widespread abuse of dispensary privileges on the part of people who can afford to pay for medical services. It is more than doubtful if there is much to sustain this view. At a recent convention of the American Hospital Association in Boston the President of the Association vigorously expressed the opinion that this alleged dispensary abuse did not deserve much consideration. Many other experts in dispensary work are of the opinion that the term "dispensary abuse" ought to be construed to mean abuse of patients on the part of the dispensary, and not abuse of dispensary privileges on the part of patients. This conten-

tion is strongly supported by the facts disclosed in the investigation of Gouverneur Hospital. (Page 459.)

It is open to question whether a public dispensary should be entirely free, or whether a nominal fee should be charged, and if so, how much. It seems only fair to protect the private physician who gives his services free, or for a nominal remuneration, by refusing admission and treatment to those who can afford to pay for medical service. The usual fee now charged in many dispensaries is ten cents per visit, which does not begin to cover the expenses of an adequately organized out-patient department. Two of the leading dispensaries in Boston have recently advanced the fee for adult patients to twenty-five cents for the first visit, and ten cents for each subsequent visit. In special clinics the charge is greater, varying with the nature of the service. In the eye clinic of one of these dispensaries the charge for the first visit is one dollar, and for each subsequent visit fifty cents. The aim is to place this clinic on a self-supporting basis, compensating the medical service, and yet meeting the need of those who are willing to pay something, but are unable to pay the regular fee of a skilled oculist. Arrangement is also made to give treatment to those who cannot afford to pay anything.

The adoption and faithful observance of such a policy would serve to reduce to a minimum the improper use of dispensary privileges. An experienced admitting officer can readily detect the more flagrant cases, and the suspicious ones are open to investigation through the Social Service Department or other means. It would also seem advisable to bring about a districting of the City along the line of the Associated Tuberculosis Clinics, assigning a certain district to each of the leading dispensaries. This would promote efficient investigation, and help to deter those applying for treatment who could afford the services of a private physician.

In regard to the pauperization of those receiving free benefactions, it must be said that there is an important distinction between the rendering of medical service and the bestowal of material goods. There is some reason in the argument that free gifts of food and clothing increase dependence, since the individual should be able to provide sustenance and shelter for himself and his family. Anyone who cannot do this is rightly considered a failure, but this does not apply to cases of disease. Sickness and injury are often due to causes beyond the control of the individual, and the family budget that is just adequate to provide for the necessities of life has no margin for the proper treatment of disease. A family of six may be independent on an income of $12 or $15 a week and yet would not be able to meet the added expense of sudden sickness. The City's free medical service would not break down the independence of such a family; rather it prevents dependence while removing the cause and re-establishing the family on a self-supporting basis. It can hardly be asserted that the family would relapse into dependence by wilfully inviting sickness, and so far as free medical service safeguards the community and promotes social efficiency, it is a legitimate part of municipal expenditure.

Social Service

Social service work in connection with hospitals and out-patient departments has been a development of recent years. In her forthcoming book on *Social Work in Hospitals*, published by the Russell Sage Foundation, Miss Ida M. Cannon, of the Massachusetts General Hospital, de-

scribes several forms of social service work, beginning with the after-care of the insane in England in 1880. These "expressions of social interest," as she calls them, differ from social work as we now know it, and which had its beginning in Boston in 1905, when Dr. Richard Cabot, for the purpose of improving dispensary service, introduced the social worker as a means of securing a more accurate diagnosis and rendering more effective treatment. The idea was soon adopted by Bellevue and other leading hospitals and dispensaries in this City and elsewhere, and, notwithstanding objections raised, a well-organized social service department is more and more considered a necessary adjunct in rendering effective medical service.

Social service finds its justification in the interdependence of social and medical diagnosis. The physician seeks to ascertain the nature of the illness of the patient and its cause as best he can, and prescribes treatment, but he cannot go beyond the examination of the patient and investigate the social cause of the ailment, whether due to family or home conditions, to the nature of his employment, or other causes. For this information he is dependent upon the skilled social worker, and in her absence his prescription might be valueless, although the diagnosis was correct. An illustration taken from Miss Cannon's book will make this clear:

> A nervous little girl of fifteen was once referred by a neurologist to a social service department with the request that she be sent to a class for stammerers. A teacher of articulation had told the neurologist that he would gladly take some patients in his Saturday afternoon class. Realizing the social and economic handicap of her affliction, she stammered out her appreciation of this opportunity, which was all the better because it would not interfere with her working time. A talk with the patient and a visit to the home revealed the fact that this anemic, nervous girl was working nine hours a day in a net and twine factory, where her fingers were flying every moment; that daily she walked a mile to her work and a mile back; and that at the end of the day she returned to cold rooms and to entirely inadequate food, improperly prepared. The mother, a prematurely old widow with two daughters, worked all day in a factory—though she was entirely unfit for it—and had no strength after her work to attend to the physical needs of her family. The total income of the family was eight dollars a week. Through the effort of the social service department, the church and a relief agency were called upon to supplement the income and the patient was sent away for several months' rest. After a year of watchful oversight the social worker succeeded in bringing the patient to the condition where she was fit to have the training in speech.

It is obvious that cases of this character require the services of a social as well as a medical diagnostician. It is not sufficient to offer medical aid in the clinic rooms if there are conditions in the homes of the patients that militate against the effectiveness of dispensary treatment. The social service worker must be called in to supply the necessary information upon which successful treatment can be based.

In the investigation of the work of the Gouverneur Out-Patient Department it was found that from 50 per cent. to 88 per cent. of the patients did not return to complete the treatment which they had begun. A large part of the effort thus wasted was due to the inefficiency in the operation of the Out-Patient Department itself, but there were other factors, such as ignorance on the part of the patients, physical inability to return, and unwholesome sanitary surroundings, which prevented successful treatment. An efficient social service bureau undoubtedly could have prevented a great deal of this wasted effort, as is shown by the following comparison between the work of the Gouverneur and the Presbyterian Out-Patient Departments, which, in the latter institution, has a well-organized social service bureau, with visiting nurses, as part of its work. One hundred

cases were taken at random from the files of the Presbyterian Out-Patient Department and investigated in the homes by agents of your Committee. These were cases in which patients did not benefit by the dispensary treatment and were referred by the clinic doctors to the social service bureau for investigation. In 83 of the cases the patients were either benefited or cured by the combined medical and social service, and in 17 cases the benefit was not apparent. In 13 of the 83 cases extra assistance, in shape of food, clothing, or removal to a more favorable place for convalescence, was given to make effective the medical treatment.

A few of these cases from the Presbyterian Out-Patient Department are compared below with other cases taken from your Committee's investigation of the Gouverneur Out-Patient Department. While the cases are not precisely similar, they are enough alike in character of disease and home conditions to warrant the supposition that a result similar to that of the Presbyterian Hospital might have been obtained in the Gouverneur dispensary with the aid of an efficient social service department.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Annie S——, 7 years, No. — Cherry Street. Very delicate, sickly child; has been so ever since birth. Taken to Out-Patient Department January 11, 1913. Diagnosis: chorea. Made two subsequent visits. Has not been benefited by treatment. Is still very weak; no appetite. The hygienic condition of home very bad. There are 3 other children, all weakly. Father earns from $7 to $9 per week; is unable to secure the treatment which Annie needs.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Minnie J——, 11 years, No. — E. 81st Street. Very nervous and unruly. Mother has 4 other children to take care of; could not attend to patient. Taken to Out-Patient Department March 18, 1913. Diagnosis: chorea. Not benefited. Subsequent visit March 25th, 1913. Referred by doctor to Visiting Nursing Department. Nurse visited home March 26th. Put patient to bed; administered medicine according to doctor's prescription; observed progress of patient's condition, and advised as to diet and treatment. Patient did not improve, and upon nurse's suggestion mother brought patient to Presbyterian Hospital April 8th. Discharged May 29th improved. Sent to country by Social Service Department to complete convalescence.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Geo. S——, 2 years, No. — Madison Street. Had fever and bad cough. Was taken to Out-Patient Department January 17, 1913. Doctor superficially examined patient. Diagnosis: bronchitis. Patient grew worse. Mother took patient to private physician, who diagnosed pneumonia. Hygienic condition of home extremely bad; personal habits of mother careless. Treatment of patient at home unsatisfactory.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Josephine O——, 4 years, No. — E. 77th Street. Was feverish and had sore throat. Taken to Out-Patient Department April 14, 1913. Diagnosis: broncho-pneumonia. Case referred to Visiting Nursing Department for observation and treatment. Visiting nurse called April 15th; took temperature; applied mustard plaster; and instructed mother to keep patient's mouth and tongue clean. Called again April 16th; found patient fretful and irritable; condition unimproved. Advised mother to take child to Hospital. Patient admitted to Hospital and after 6 days stay was dismissed cured.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Celia P——, 12 years, No. — Pitt Street. Troubled with diseased tonsils. Taken to Out-Patient Department Janu-

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

George F——, 7 years, No — E. 98th Street. Had swollen tonsils. Taken to Out-Patient Department November 30,

ary 7, 1913. Diagnosis: follicular tonsillitis. Doctor of Out-Patient Department directed patient to stay in bed. Made two subsequent visits to Out-Patient Department, but condition of patient still very bad. School doctor said patient must have tonsils cut; possibility of developing consumption; child unruly and irritable. Mother is helpless and cannot induce her to undergo the necessary operation. Sanitary condition of building extremely bad. Family consists of 2 adults and 3 children; living in 3 small, semi-dark rooms; unclean condition. Patient has no father and family is assisted in paying rent by United Hebrew Charities.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Izzy F——, 5 years, No. — Henry Street. A weak, underfed and anemic child. Had a harsh cough. Taken to Out-Patient Department January 9, 1913. Diagnosis: laryngitis. Was given medicine. Patient was not relieved and received no further medical attendance. The family subsists on $5-6 per week; mother, and baby, 6 months old, look half-starved; father has weak heart. The home is filthy; sanitary condition of building extremely bad.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Mamie Y——, 3 years, No. — Cherry Street. Coughs and has defective tonsils. Was taken to Out-Patient Department on January 7, 1913. Diagnosis: tonsillitis. Doctor advised patient's mother to see that child's tonsils be removed. Made 11 subsequent visits to Out-Patient Department; was given medicine each time. Mamie's condition has not improved. The home lacks cleanliness and ventilation; 3 small, dark rooms. Family income $11 per week; 2 minors to be supported.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Benj. B——, 11 years, No. — Montgomery Street. Had a cough and pain in left side. Taken to Out-Patient Department January 13, 1913. His throat was examined. Diagnosis: bronchitis. Patient's condition became worse. Called again at Out-Patient Department; was given medicine, but was not relieved. Mother took him to Beth Israel Dispensary, where doctor diagnosed empyema and said patient is to undergo an operation immediately. Patient's father is af-

1912. Diagnosis: tonsillitis. Doctor of Out-Patient Department referred case to Visiting Nursing Department with directions to nurse to demonstrate use of gargle. Visiting nurse called November 30th, showed patient how to gargle and took temperature. She made 3 more visits and advised patient to go again to Dispensary for further examination by doctor. Nurse called again after patient's visit to Dispensary. Noticed that patient's brother had a sore throat. He also was made to gargle with brother's medicine. Visiting nurse obtained two free tickets admitting both brothers to a special nose, ear and throat dispensary to have their tonsils cut. Social Service Department of Presbyterian Hospital supplied family with milk during the period of patients' illness. Patients now improved; waiting for opportunity to have tonsils removed.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Sam D——, 6 years, No. — E. 66th Street. Was coughing. Taken to Out-Patient Department. Diagnosis: laryngitis. Doctor of Out-Patient Department referred case to Visiting Nursing Department for treatment. Visiting nurse called January 29, 1913. Demonstrated to patient use of steam inhalation; called again January 30th and advised mother to take patient to Dispensary for final examination. Patient taken to Dispensary, examined and dismissed improved.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Marion S——, 2 years, No. — E. 73d Street. Had swollen tonsils. Was taken to Out-Patient Department May 6, 1913. Diagnosis: tonsillitis. Doctor referred case to Visiting Nursing Department for further treatment. Visiting nurse called May 7, 1913; examined patient's throat; took the temperature and administered medicine. Made 4 subsequent visits and dismissed case improved.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Mary L——, 9 months, No. — E. 75th Street. Had a cough and fever. Taken to Out-Patient Department February 22, 1913. Diagnosis: broncho-pneumonia. Doctor of Out-Patient Department referred case to Visiting Nursing Department for observation and treatment. Visiting nurse called February 22, 1913; gave patient alcohol sponge; took temperature, etc. Made 2 more visits. Condition of patient unimproved. Nurse suggested that patient be sent to Hos-

flicted with tuberculosis; is not receiving any medical attention. Mother ignorant and careless, and has no conception of the danger of tuberculosis infection. Two adults and 6 children are occupying 3 small rooms.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Mollie J——, 10 years, No. — Montgomery Street. Has trouble with heart. Taken to Out-Patient Department January 22, 1913. Was examined; no diagnosis. Medicine did not help her. Is very weak and anemic. There are 2 or more cases of tuberculosis in family. Hygienic condition of home extremely bad. Three dark rooms in basement filled with old filthy garments. Income uncertain; extreme want and poverty.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Isidor F——, 7 years, No. — Monroe Street. Had swollen tonsils. Taken to Out-Patient Department January 24, 1913. Diagnosis: tonsillitis. Was given medicine; not benefited. Called again at Out-Patient Department and given more medicine. Sick in bed 1½ weeks, during which time received no medical treatment. Child's tonsils still very painful. Father and mother rag-peddlers; income uncertain. There is no one to take care of home and children. Floor covered with rags and dirt of every description. Two adults and 5 children live in 3 rooms; 2 absolutely dark.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Sarah F——, 8 months, No. — Gouverneur Street. Had heavy cold and stomach disturbance. Taken to Out-Patient Department January 7, 1913. Diagnosis: bronchitis. Given tablets to clear stomach. Patient did not improve. Taken again to Out-Patient Department, but received no relief. Baby still suffers from constipation, is losing weight and is generally very weak. Family consists of 3 adults and child, living in 4 dark rooms. No proper ventilation; lack of cleanliness.

GOUVERNEUR OUT-PATIENT DEPARTMENT.

Dave Z——, 6 months, No. — Cherry Street. Had serious stomach disturbance. Taken to Out-Patient Department pital. Mother refused to do so, but instead called in a private physician who treated patient. Visiting nurse continued daily visits from February 25th to March 15th, when patient was dismissed improved to Dispensary.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Catherine F——, 7 years, No. — E. 75th Street. Suffering from weak heart. Taken to Out-Patient Department March 18, 1913. Diagnosis: valvular disease of heart. Doctor of Out-Patient Department referred case to Visiting Nursing Department. Visiting nurse called March 19, 1913. Investigated living conditions of patient; applied ice bag on patient's heart, and told her to remain in bed. Visiting nurse made 3 more visits; instructed patient how to take care of herself. Dismissed case improved to Dispensary.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Theresa M——, 3 years, No. — E. 69th Street. Had pains in throat. Taken to Out-Patient Department February 19, 1913. Diagnosis: acute follicular tonsillitis. Case referred to Visiting Nursing Department for attendance and treatment. Visiting nurse visited home February 20, 1913. Investigated living conditions of patient; irrigated throat and took temperature. On second visit taught patient how to gargle. Visiting nurse made 3 subsequent visits. Condition of patient much improved. Dismissed case to Dispensary February 24, 1913, improved.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Alice C——, 13 months, No. — E. 85th Street. Had cough and stomach disturbance. Taken to Out-Patient Department July 19, 1913. No diagnosis. Case referred to Visiting Nursing Department for treatment. Visiting nurse called July 20, 1913; investigated home conditions; advised mother as to proper ventilation; prepared patient's food, and obtained eggs and baby clothes for patient from Social Service Department of Presbyterian Hospital. Continued visits up to September 12, when patient was sent to Presbyterian Hospital for treatment. Discharged from Hospital October 24th; patient had whooping-cough. Visiting nurse resumed visits and on January 8, 1913, patient was dismissed to Dispensary improved.

PRESBYTERIAN OUT-PATIENT DEPARTMENT.

Raymond A——, 13 months, No. —— E. 78th Street. Was taken ill with stomach disturbance. Taken to Out-Patient

January 3, 1913. Diagnosis: entero-colitis. Made 2 subsequent visits; was not benefited; sick 3 weeks. Patient's ear is in a diseased condition; is not being treated. Home lacks cleanliness and proper ventilation. Mother ignorant as to diet and general care of baby.

Department February 18, 1913. Diagnosis: entero-colitis. Case referred to Visiting Nursing Department for treatment. Visiting nurse called daily from February 18 to March 3, 1913. Made irrigations, prepared food and carefully watched condition of patient. The baby failed to improve. Visiting nurse advised mother to take child to Hospital. Patient admitted to Hospital March 3, 1913, and dismissed improved March 17, 1913.

It is apparent from the foregoing that there are numerous cases of sickness which cannot be relieved merely by the treatment offered in the clinic, no matter how excellent it may be. The clinic must be supplemented by a social service bureau. The experienced social worker must join with the physician in dealing, among others, with the following cases:

1. Cases which do not seem to respond to the treatment given in the clinic should be referred to the social service bureau for investigation in the home, to determine, if possible, what conditions of the home surroundings are responsible. If additional relief is needed, such as food or clothing, removal to a home for convalescents, or change of occupation, the necessary steps should be taken to furnish the needed relief directly, or in coöperation with the charitable agencies of the City.

2. Patients whose condition, from a preliminary inquiry at the admission desk or in the clinic, seem to require a more searching investigation than can be made at the dispensary; and all cases of a certain class, such as heart cases, neurasthenics, etc., may be automatically referred to the social service bureau.

3. Cases in which it is especially essential that the patient should return for continued treatment should be referred to the social service bureau for investigation if they fail to do so. If the failure is due to ignorance, negligence, physical inability, or other cause, the necessary steps should be taken by the social worker to secure continued treatment. An efficient follow-up system should be maintained for this class of cases.

4. Patients whose condition is such that they cannot well return to the clinic, and yet is not serious enough to necessitate removal to a hospital, should be referred to the social service bureau for care in the home. If the patient is improved under such care he should be sent to the clinic for final examination by the doctor before being discharged as cured. If not benefited patients should either return to the clinic or be removed to the hospital.

5. Convalescent patients who are discharged from the hospital to give room for more serious cases may be referred to the out-patient department for occasional treatment; for supervision in the home by the social service worker; or possibly for removal to a convalescent home, if necessary.

6. Obstetrical cases under the observation of that clinic should be referred to the social service bureau for nursing during and after parturition. The importance of trained nursing to the health of the mother and child is inestimable. Through the instruction of the obstetrician in the clinic and the visiting nurse in the home it is possible to overcome the dangers of the extensive midwifery practice. The following from the Sec-

ond Report (1912) of the Social Service Department of Lakeside Hospital, Cleveland, O., indicates the opportunities in this direction:

> III. The number of confinements attended by the substitutes for midwifery was larger than for the previous year. These substitutes, each of which represent a type, are as follows:
>
> 1. Private physicians, who for nominal or no fees, delivered 433 women, and the district nurses of the Visiting Nursing Association furnished the nursing care.
>
> 2. The Maternity Dispensary of St. Luke's Hospital delivered and cared for 205 cases in the homes.
>
> 3. The Obstetrical Department of the Dispensary of Lakeside Hospital and Western Reserve University assisted by Senior Students delivered 540 cases in the homes, and Lakeside Hospital furnished the nursing care for these women and babies.
>
> This is a total of 1,178 cases delivered in the homes, a goodly number, but just one-eighth of what it soon must be, if we eliminate the midwife, and at that without any allowance for the growth of the City. These three represent all the types of substitutes ever developed to displace the midwife except the hospital, but maternity hospitals are not in themselves an economical or efficient substitute for midwifery; they are, however, essential to the success of each of the other types of substitutes mentioned. They are not economical, because of the high cost of construction and equipment of hospitals (at least $6,000.00 for one bed and crib) and of the maintenance cost amounting to at least $4.00 per day for mother and child. They are not efficient because these women will not as a rule voluntarily go to a hospital unless convinced that it is absolutely necessary, and an aggressive attempt by a hospital to secure patients would be misunderstood and therefore futile.

This last class of cases, and others cited above, call for the services of a visiting nurse rather than a social worker. The chief function of the trained visiting nurse is to render such nursing service as may be required by sick people who are cared for in their homes instead of in a hospital; she is only incidentally interested in the social causes of disease and the economic condition of her patient. To the social worker, on the other hand, the successful completion of the medical treatment is only part of the problem. Her chief concern is to make a social diagnosis of disease, to judge of the family and social causes which may have brought about the breakdown and sickness of her patient; in order, first, to aid in the recovery of the patient; and, second, by finding a remedy for evil conditions, to place the patient on a better footing than before. By some it is held that this function of the social worker can be performed by a trained nurse in addition to her nursing service. Others hold that the training of a nurse does not fit her for successful social work, and that the social worker should confine herself to those cases that require both social and medical treatment, and turn over those cases requiring only nursing service or physical relief to nursing associations or relief agencies. This latter view is strongly and comprehensively set forth by Miss Cannon in her book on hospital social work, already referred to.

In actual practice the functions of the social worker and the visiting nurse are likely to overlap. The difference of opinion as to their proper sphere must be left for future determination. The best methods by which the social worker can make use of other agencies for social welfare are still in process of being worked out. It may be observed, however, that it would not seem advisable for the profession of social work to enter a field already occupied. Rather, in fulfilling her own distinctive mission, the social worker should enlist the coöperation of relief societies, district nursing associations, and other social agencies of the community.

ORGANIZATION AND RECORDS OF THE OUT-PATIENT DEPARTMENT

An efficiently organized and adequate staff is essential if the best results are to be secured. Not a little of the ineffective treatment at Gouverneur Hospital has been due to a lack of organization, as well as to a lack of facilities. But even the best of facilities will not of themselves insure good work. There must be an administrative head of the out-patient department; an adequate medical and nursing staff; and a social service bureau or department.

General Administration

The out-patient department should be in charge of a medical officer who, under the general direction of the superintendent of the hospital, should be responsible for the work of all employees in the dispensary, and all administrative details, except the work of the medical staff. An assistant superintendent of the hospital might be assigned to this position, which would facilitate the closest coöperation between the hospital and the out-patient service. In any case there should be adequate remuneration and a sufficient tenure of office to insure the services of a capable and experienced officer.

The method of admitting patients should receive the most careful consideration. All the patients entering the dispensary must come to the admission desk for a preliminary inquiry; either to be sent away, if not deemed admissible for treatment, or, if admitted, to be assigned to the proper clinics. It is, therefore, the most strategic point at which to study the dispensary population and its needs. Varying methods of admission are used in different institutions. In one well-organized out-patient department this function is performed by the superintendent himself, who is a medical officer, and who, after a few pointed questions, supplemented occasionally by a brief examination, assigns the patients to their respective clinics, or refuses admission, as the case in his judgment may require. In another out-patient department this work is entrusted to an experienced social worker. Here a close inquiry is made into the social condition of the patient, to learn, if possible, whether social as well as medical treatment may be needed. This takes more time and often requires the aid of two or three well qualified assistants. One of these is a man, who is thought better fitted than a woman to interview certain adult male patients. In still another out-patient department these two methods are in part united; that is, the director has charge of the admission work, assisted by several trained social workers. The purpose here is, by a searching inquiry into the patient's social condition at the admission desk, to avoid most of the work of investigation in the patient's home, otherwise deemed necessary. As has been stated, this requires much time, but it is claimed that the opportunity afforded to study the patient, and the information secured, are worth all it costs. The varying methods have not been sufficiently worked out to make it safe to dogmatize as to which is the best, though there is a tendency to regard the admission desk as the logical place for the social worker. Whatever the method used the work should be entrusted to a

competent official and not left to a subordinate employee, as is now done at Gouverneur dispensary.

The foregoing applies, of course, only to the new patients who come to the out-patient department from day to day, and who must be separated from the old patients returning after the first visit for additional treatment. In investigating the work of Gouverneur dispensary it was found that there was great danger from the presence of cases of contagious diseases in the crowded waiting room. Many other out-patient departments have already provided means for the segregation of such cases immediately after entrance. A well trained officer, either a physician or a trained nurse—preferably the former—should be stationed close to the door, for the purpose of observing more or less closely, the incoming people. Those showing suspicious symptoms of scarlet fever, measles, whooping-cough, etc., should be immediately taken to the detention room for more careful examination and a proper disposition of the cases. This officer could at the same time separate the old patients from the new ones. The former would be sent direct to the registration desk to pay their fee and secure the card for admission to the clinic. The new patients would first have to go to the admitting officer to secure admission for treatment, and would then pass on to the registration clerk along with the old patients.

The Medical Staff

The patient comes to the out-patient department to be cured of some illness, more or less severe. All things else must minister to this end. At any time the patient is admitted he should be given the best help the dispensary has to give. The medical service must be maintained at a uniformly high level every day in the week and every week in the year, and there must be the closest coöperation in the treatment of cases, between the several clinics, and between these and the hospital. It is urged by good authorities that the best way to secure good service is to have the physicians and surgeons in the out-patient department occupy corresponding positions on the hospital staff. This would attract the best men, because of the greater experience and prestige derived from the hospital service. The plan appears ideal, but it is doubtful whether it could be practically applied in connection with the out-patient departments of our municipal hospitals. A modification of the plan, however, may be adopted by having the chiefs of divisions of the out-patient department occupy the corresponding positions in the hospital. These chiefs, or their duly qualified assistants or deputy chiefs, should be present in the clinics at all times, and have a close supervision of the medical and surgical service. Such an arrangement would facilitate the transfer of patients from the out-patient department to the hospital, or *vice versa*, and insure the necessary coöperation.

Members of the medical staff usually give their services free. There are some exceptions, as at Gouverneur, where a small payment is made. The out-patient department is supposed to offer free treatment to those who cannot afford to pay for the services of a private practitioner, and the medical man, therefore, is expected to serve without payment, his only compensation, aside from his desire to aid in charity work, being the experience gained by the examination and treatment of a large number of cases, and the opportunity offered for a scientific study of disease. It is questionable whether this system of gratuitous service insures good results. The best service is likely to be secured if the clinic is utilized for teaching

purposes. In this case the instructors in the medical school would have positions assigned on the out-patient staff, and, being closely observed by the student, would give careful attention to correct diagnosis and treatment. If there is no teaching done, however, and if for other reasons it is found difficult to obtain good men for the out-patient staff, it may be necessary to pay a fair remuneration for medical service in order to secure a better quality of work and prompt attendance at the clinic. The chiefs of divisions who are required to give most, if not all, of their time to the work, must be paid a sum sufficient to attract capable men for these responsible positions.

It has already been pointed out that the out-patient department should not limit its service to the very poor. People of moderate means, willing and able to pay something, often find themselves unable to secure the needed services of a skilled specialist. To meet the requirements of these people various arrangements have been made in several out-patient departments. In one dispensary a charge of one dollar is made for the first treatment in the eye clinic, and fifty cents for each subsequent visit. Arrangement is made by which glasses are furnished by competent opticians at moderate rates to those who can pay, and free to those who cannot. The director of another out-patient department states that, "under the old way of sending prescriptions out for the filling there is so much graft and so much poor work, in addition to the large number who fail to get any glasses, that I believe the system entirely inadequate and out of date." Unless the optician's part of the work is well done the services rendered by eye clinics will be largely fruitless. In the orthopedic, physical therapy, and other clinics where specialists' services are required, similar arrangements may be made, compensation being paid by the out-patient department for the services of such specialists, and suitable fees collected from the patients who can afford to pay.

The number of physicians and surgeons in each clinic depends on so many factors that no arbitrary rule of any value can be laid down. The number of patients attending the clinic will not afford a sufficient guide, owing to the widely varying character of the work and the difference in capacity on the part of members on the medical staff. Much will also depend on the amount and character of assistance given to the physicians and surgeons in the clinics by nurses in the preparation of patients, the taking of temperature, etc.; and by the social service worker in securing social information necessary for correct diagnosis and treatment. An efficient administration also will see to it that the patients are brought to the doctor in rapid succession, so as to avoid a waste of the physician's time, and that adequate facilities are furnished and necessary material ready to his hand. The number of physicians and surgeons needed at each session of the various clinics can probably best be determined by the chiefs of divisions, from time to time. There should be a large enough medical staff to insure careful diagnosis and adequate treatment to all patients coming to the clinics.

In this connection the following data, obtained from Dr. S. S. Goldwater, Superintendent of Mt. Sinai Hospital, will be of interest. The out-patient department of this Hospital is quite large, averaging last year 782 patients per day in all departments. During February, 1913, the number of consultations and the average number of minutes for each consultation in the separate departments were as follows:

Department	Total Number of Consultations	Average Number of Minutes for each Consultation
Children's	2,203	9 2/5
Surgical	3,277	7 1/2
Tuberculosis	313	11 3/10
Medical	3,210	8 3/5
Ear and Throat	1,489	8 2/5
Gynecology	1,051	12 3/10
Genito-urinary	527	12 1/5
Neurology	1,460	5
Eye	1,058	7 7/10
Skin	1,107	8
Orthopedic	601	9 3/10
Radiotherapy	313	6 9/10
Physical Therapy	598	7 1/4

In the several divisions within the same clinic there was found to be a wide variation in the average time for each consultation. In one division of the children's clinic, with 256 consultations, the average time was 4 3/5 minutes; in another division, with 281 consultations, the average was 15 minutes. In the surgical clinic, one division, with 322 consultations, showed an average of 7 7/10 minutes, and another, with 318 consultations, an average of 12 1/2 minutes. In the medical clinic the average time in one division, with 237 consultations, was 2 4/5 minutes; in another division, with 344 consultations, it was 14 minutes. Similar variations occurred in other clinics. As this dispensary is endeavoring to improve the quality of its out-patient work the average time here given for each clinic may probably be considered a minimum, but in view of the wide variations noted within the same clinics it should be taken as indicative of what is being done, rather than as a standard to be followed in other out-patient departments.

The Nursing Staff

More and more consideration is being given to the work of the nurse in the out-patient department, both because of the training she receives and the services she can render by relieving the physician or surgeon from certain work which can be just as effectively done by the nurse, such as assisting in the undressing of patients; in bandaging and unbandaging; in the preparation of materials; etc. Owing to the common disregard of dispensary patients, nurses have not been assigned to this work, and yet the members of the out-patient staff treating a continual stream of patients are in need of a nurse's assistance. An ample nursing staff will be an added incentive in attracting good men to the out-patient service, because, being relieved of unimportant details the doctor can devote his entire time and interest to actual medical treatment. It is also desirable that the nurses should have some experience in the out-patient department as part of their training, as they will there have to do with certain classes of patients and certain kinds of work not found in the hospital. As the nurses are always under the direct observation of a physician or surgeon, the work in the out-patient department may well be done by pupil nurses assigned from the training school of the hospital during the last year or six months of the course, and under the general oversight of a trained supervising nurse.

The number of nurses assigned to the various clinics should be determined by the amount and character of the work to be done, rather than by the number of physicians and surgeons. There should be enough nurses to relieve the physicians and surgeons of all unnecessary detail. There should probably be at least one nurse for each clinic; in certain special clinics and in those with a large attendance more may be needed. In the children's clinic, in the general surgical, the skin, the genito-urinary, and others, one nurse to each two doctors may be found a workable ratio; in other clinics, as the medical, one nurse to each three or four physicians may be sufficient. The actual number of nurses to be utilized with advantage can be decided only in the light of experience, after consultation between the chiefs of divisions and the director of the training school having general charge of the nurses' training.

Social Service Staff

The function of the social service bureau has been dealt with at some length. Methods of organization vary widely in different institutions. Sometimes the social service bureau is affiliated with, or is a part of, the nurses' training school, and sometimes it is under a volunteer committee recognized by the hospital authorities. The former plan is strongly advocated by some good authorities, but whether it is advisable or not will depend on how much visiting nursing is to be done. In the City's out-patient departments the best form of organization will probably be to have the social service bureau independent of both the training school and the medical staff. The bureau should have charge of all social service work in the out-patient department and in the hospital, and the head worker should be responsible directly to the superintendent of the hospital.

Plans of operation are still in the process of being worked out. Various methods of selecting patients for investigation by the social worker have been suggested—the admission desk has been spoken of as a strategic point where the social worker has especial opportunity to study the social conditions of the patients; the physicians and surgeons also are expected to refer patients to the social service bureau when it seems to be required. But it is felt by many that these methods are inadequate; many patients will escape the social worker at the admission desk, and the physician is often hurried in his work and untrained in judging of social conditions. The plan of placing the social worker directly in the several clinics, in addition to the nurses, has been adopted in the Boston Dispensary. The social worker interviews the patient; takes the social history; performs the function of a social diagnostician; and confers with the physician as to proper methods of treatment of such cases as may require it. The plan is said to work very well; it has been adopted to some extent in the Massachusetts General and other out-patient departments, and may prove to be the ultimate plan to be followed.

This plan will, of course, require a larger number of social service workers, but it promises also more work done and better results. It should be tried. At least four or five trained social workers should be assigned to appropriate clinics in the Gouverneur Out-Patient Department, such as the children's, and there should be, in addition, several others on the staff of the bureau for general assignment. This number may then be increased as experience seems to justify it. If it is found necessary to do the work of visiting nurses some of those on the staff must be trained nurses. It is

thought to be inadvisable to have the visiting nursing done by pupil nurses, as they have not the necessary qualifications and training, especially in judging of social conditions. Only for the purpose of experience and training should senior pupil nurses be permitted to do this work, and then only under strict supervision of experienced workers. The social service bureau should not assume too many functions. It should avoid duplicating the effort of other agencies, and confine itself chiefly to the function of social investigation and social diagnosis. For this special work the trained social worker will be needed.

Medical and Social Records

The records in many out-patient departments are kept in a more or less haphazard manner, and often there are no records of any kind; yet, a good record system is essential for efficiency, both in the general administration and in the medical service. It is probably not too much to say that the quality of the medical service is indicated quite accurately by the character of the records kept. The physician often finds it necessary to inquire into the patient's family history and his past habits, and may, in addition, require information about his social condition, before an accurate diagnosis can be made and successful treatment prescribed. The systematic recording of both social and medical facts regarding a patient is of greatest importance, not only for the correct diagnosis of present ills, but for future reference, for teaching purposes, and for social investigations.

In the study of a considerable number of cases made at the Boston Dispensary it was estimated that from 25 per cent. to 30 per cent. of all cases treated at that institution were in need of both social and medical treatment. In this many cases, at least, the social information concerning the patient is indispensable to the physician if the treatment prescribed is to be successful. In many out-patient departments the medical records are kept in one place and the social records in another, and an attempt is made to make the information on the social records available to the physician by placing on the patient's medical record a reference to the social service file. Although the information of a patient's social condition is largely of an intimate and confidential nature, more and more consideration is being given to some plan of filing both social and medical histories together. In the Lakeside Dispensary, Cleveland, the medical histories are filed in an envelope on which is noted the name, the civic condition, nationality of the patient, and other social facts. In Boston Dispensary similar facts are placed at the head of the patient's medical record. Such a form of card is found in the appendix. The social information here indicated should probably be taken of all patients admitted for treatment, either at the admission desk or in certain clinics, as might be found to be the more convenient. A more detailed social record could be taken of those patients referred for investigation to the social service department.

The forms of records used vary widely in different institutions. No standard has as yet been adopted, and practically the records of no two institutions are quite alike. It would seem unnecessary that each out-patient department should have a system of records different from all others, but the point has hardly yet been reached where a form for general use can be proposed. A suggested form for the general medical and gynecological clinics will be found in the appendix. Similar forms for other clinics will vary with the requirements of those clinics. It will be noticed that a con-

siderable number of items are printed on these records, so that the physician need only check off or write in its appropriate place the necessary data. It saves the physician's time, and is said to be used in some out-patient departments with satisfactory results; but this form is sharply criticized by other good authorities, who claim that it does not insure a good record, and is worthless if items are incorrectly entered. It is thought that a better history will be secured by a form with comparatively few headings, requiring the physician to write out the essential facts. The value of the record undoubtedly depends more upon the care with which it is written than upon the number of facts secured or the length of the record. The interest of the medical staff, and especially of the chiefs of the clinic, should be secured by consultation as to the best form of record suited to local requirements.

As the systems of records differ, so also do the methods of filing. In some out-patient departments the records are filed in the different clinics, while in others the records of the smaller clinics are filed in one central record room; those of the larger clinics, as the general medical, being filed separately in those clinics. In several well-organized dispensaries the system of filing is completely centralized; that is, all records are kept in one room, placed in charge of a filing clerk. From these files the histories are taken and sent to the clinics when the patients apply for treatment. Some dispensaries entrust the records to the patients themselves, and claim that no serious loss of records or other inconvenience results therefrom, but in other dispensaries, using the centralized system, it is held that under no circumstances should the patient be in possession of his own medical and social history, which should be sent directly to the clinic by pages employed for the purpose, or by other means. The patient's history is filed by number, and a name index to the records is made on a small card. A diagnosis index on a similar card is also made in some institutions, so as to bring together all cases of the same class. This is of special importance to the physician, and quite indispensable for teaching purposes.

Blank forms should be provided to facilitate the work of the out-patient department, and the coöperation of the various clinics with each other and with the hospital. Various forms for these purposes will be found in the appendix.

Standard Formulæ for the Pharmacy

In an out-patient department where there will be so many cases of like character treated, and where there will necessarily be so many similar prescriptions, a great saving in time is effected by having certain standard formulæ for prescriptions, each of which would be known by some characteristic title. These standard formulæ should be printed in booklet form and given to each physician and surgeon and to the drug room assistants. Apothecaries working at periods when patients are not in attendance, or when the attendance is light, would prepare large quantities of these standard prescriptions and have them ready to dispense to patients during the busy hours. The advantage of this sort of preparation is, of course, obvious. In Mount Sinai Dispensary, New York City, it was found, on actual count, that by the use of a formulary which had been elaborately worked out in that institution it was possible to dispense 100 medications in five minutes. In out-patient departments where such preparation has not been made there is a great deal of time spent at the drug room window, waiting for prescriptions to be filled, with a resulting congestion at that particular point.

THE PHYSICAL PLANT

Location and Site

If the out-patient department is operated in connection with the hospital it is, of course, more economical, both as to construction and operation, to locate it in close proximity to the hospital. One heating plant and one drug room would suffice for both institutions, and the hospital laundry would be available for necessary work. Certain expensive equipment need not be duplicated, if already provided in the hospital, such as X-ray and hydro-therapeutic apparatus, and the accident ward of the hospital might be advantageously merged with the out-patient department, as has been done in several instances, and patients could be more easily transferred from the out-patient department to the hospital or from the hospital to the out-patient department, as might be required.

In choosing a site for an out-patient department first consideration should be given to light and ventilation. Good light is especially desirable in the surgical rooms and in those used for skin examinations. Good natural ventilation should be secured wherever possible, although this may have to be supplemented by a system of artificial ventilation, particularly where the attendance is very heavy. The most desirable site, of course, would be one removed from the noise and dust associated with heavy traffic and large factories, as these conditions seriously interfere with the work in many departments.

Size and Type of Building

The area of the site available for an out-patient department will often determine the type of building to be erected; especially in New York, where the area is usually very much restricted, and the rectangular type of building of two or more stories, therefore, most common. Where an expansive site is available, however, it may be well to consider the relative advantages of several types of buildings. Whatever the type of building to be erected the size will be determined by the average and maximum number of patients, both new and return cases, treated daily in each clinic; by the number and character of the clinics maintained and the facilities placed at their disposal; by the number of daily sessions held by each of these clinics; by the number of students and attendants and the amount of teaching done, if any; and by the waiting room and other provisions to be made for the convenience and comfort of both physicians and patients.

1. The one-story building has certain obvious advantages in making stairways and elevators unnecessary. It assures good light and good ventilation. It is comparatively easy to keep the incoming and departing patients separate, and to direct the patients to their separate clinics. Yet these and other advantages of a one-story building are apparently more than offset by the undoubtedly greater cost of construction and operation of such a building; much more space is needed for corridors; the cost of foundation and roofing is proportionately high; and more attendants required on account of the large area covered.

2. The L-shaped building, whether one or more stories, is a modification of the rectangular type. It affords an opportunity to place a large waiting room on each floor at the junction of the two wings. Corridors lead off from these waiting rooms to the examination rooms located in the two wings, and at the farther end of these, drug rooms are conveniently located near the exits for the patients. The confusion and commingling of different classes of patients is thus largely avoided by an orderly procedure of incoming patients to the admission desk, the waiting room, the treatment room, and the drug room near the exit; and good light and ventilation can be secured, especially in the waiting room. On the other hand, as in the case of the one-story building, a proportionately large floor area is needed for corridors, and some of the treatment rooms are too far away from the waiting rooms, requiring, with the exits, more attendants than are needed in a more compact arrangement. The two exits also require two drug rooms, at some distance from each other, which means an additional expense for attendants. When three or more stories high an elevator would be required, as in the next type of building.

3. Another type is the multi-story building, which may be rectangular or square. It is much more compact than a one-story building having the same total floor space, and the cost of construction, heating, and plumbing is therefore less than in the former type. It is also more economical in general operation, since a very large number of patients can be supervised and directed by a minimum number of attendants. It is necessary to have an elevator, but this need not be a serious objection if those departments having the largest attendance are located on the first and second floors; and a careful distribution of the clinics on the several floors will tend to prevent the confusion of one class of patients with another. If the site is large there will be an abundance of light and ventilation, but if it is restricted by adjoining buildings, careful planning will be necessary to secure the greatest amount of natural light and ventilation. On the whole, this type of building is probably to be preferred, even where a large site will permit another style of construction.

Details of Architecture and Construction

The technical details of architecture and construction should be left largely in the hands of competent architects experienced in this line of work. Only a few observations of a general nature will be made here.

The style of architecture should be strictly subordinated to the practical use of the building. As large numbers of people come daily for treatment the first requisites are safety, sanitation, ventilation, and light, and the ornamental features of the building should not be permitted to interfere with these. The construction should be fireproof, and of such material that cleanliness can be maintained continually at a minimum expense. Interior ornaments and horizontal surfaces generally should be avoided. A good architectural composition along reasonably straight lines is the best and most economical, both in construction and operation.

Heating and Ventilation

Natural ventilation is the best. The out-patient building should be located and constructed so as to permit the greatest amount of air circulation around and through the building. Transoms over the doors and windows should be provided, ventilators may be attached to the bottom of the

sash, or other fresh air inlets provided. For a large part of the year this may be sufficient. At other times, as in hot, humid days in summer, or when the windows must be closed on account of dust or noises, or in cold weather, it may be necessary to aid natural ventilation by a system of artificial ventilation. This should be of the simplest description. Exhaust fans, properly located with reference to such rooms as the waiting room, operating room, toilet rooms, and others, will serve the purpose. In heating, a system of direct radiation is to be preferred, and it should be entirely independent of ventilation.

Light and Illumination

The windows should be sufficient in size and number to provide an abundance of natural light, and should not be subordinated to architectural appearance. A glaring artificial light, fatiguing to the eye, should be avoided, as should also all forms of expensive indirect illumination. As illumination is affected to a large degree by the color and finish of walls and ceilings, these should receive due consideration. All fixtures should be of the simplest type, with no ornamentation or unnecessary angles.

Plumbing and Fixtures

All plumbing work should be exposed and kept free of the wall or floor wherever possible, so as to facilitate detection of leaks and to render cleaning easy. Basins, sinks, and other fixtures should be liberally supplied in all rooms where needed, and should be of the simplest pattern. Enameled iron can be substituted for porcelain. Nickel plated or polished brass is expensive and may be avoided. All waste pipes, traps, etc., may be painted instead of polished.

Floors

The floors of an out-patient department, as in other parts of a hospital, should be sanitary, non-absorbent, and easily cleaned. Unlike the floors of a hospital ward, where a trained nurse is always on duty, the dispensary floor need not be resilient; wood and linoleum are therefore less needed, and composition floors have not yet proven entirely satisfactory. Cement makes the cheapest fireproof floor, but is rough, absorbent, and unsightly. For certain rooms terrazzo, or tiling, or a combination of the two, will best answer the requirements of an out-patient department.

Walls and Partitions

For the finish of interior walls and partitions hard plaster is serviceable in most places; white tile is better, and, though more expensive, may have to be used in certain rooms to a height of four feet or more. A light-gray or buff color on the walls will promote illumination. The partitions, wherever possible, should be of a light construction, so that they may be easily moved in case it is found necessary to alter rooms to meet changing needs and new conditions.

Further Considerations in Planning

The floor space in an out-patient department is of fundamental importance. Efficiency in administration and the quality of work done are largely affected by the arrangement of rooms and spaces. Only such fea-

tures as directly affect the handling and treatment of patients will be here considered.

Entrances and Exits

The number and location of entrances and exits are important factors in the problem of handling large numbers of dispensary patients. Separate entrances for men, women, and children, or for different classes of patients, except as hereinafter noted, are thought to be both unnecessary and undesirable, as they are likely to lead to confusion or to cause an undue expense in maintaining proper supervision over large numbers of people unfamiliar with the arrangements. One entrance for all patients—except tuberculous and return cases of infectious diseases, if they are to be treated in the out-patient department—would be satisfactory. It is essential to administrative efficiency to provide another door for exit, so as to keep separate the incoming and outgoing patients. These doors should be close together, however, so that one attendant may be able to supervise all the patients entering and leaving the building. In the L-shaped plan of building an exit at the end of either wing, separate from the entrance, will naturally be provided, permitting the patients to be kept moving in one direction, without confusion and cross currents. But such an arrangement means more attendants, and, therefore, greater cost for supervision.

The tuberculosis clinic should be separated from the other clinics of the out-patient department, preferably with its own entrance door exclusively for this class of patients. If whooping-cough or other contagious diseases are admitted, they should likewise be isolated from other patients and provided with a separate entrance, and it is advisable that there should be still another entrance for the physicians, nurses, and attendants.

Waiting Rooms and Admissions

The entrance hall and waiting room require careful attention to avoid crowded conditions and confusion generally, especially where large numbers of those unfamiliar with the surroundings are received. It is obvious that patients should be seated close to, or in, their respective clinics, so that they may be readily called for examination and treatment, and be easily supervised by few attendants. Two plans may be considered: to provide a large waiting room on the first floor and a somewhat smaller space on each floor above, in a multi-story building, in which all patients are seated; or smaller waiting rooms in connection with the separate clinics. By the latter plan the patients are seated near the clinic in which they are to be treated, which facilitates rapid operation, but these special waiting rooms will occupy valuable space which could be used to advantage for other clinics, and they require too many attendants for supervision. A central waiting room is more compact and more easily supervised, and there is no special reason for separate waiting rooms for the sexes so long as separate examination rooms are provided. In the L-type of building, such a waiting room will naturally be provided at the junction of the two wings, but it will be distant from most of the clinics and, therefore, more attendants will be needed to bring patients to the treatment rooms at the proper time. In a rectangular building the clinics can be located on two or more sides of a central waiting room, and sections of this waiting room may be set off for different clinics by colored signs or lights, which would correspond to the color of the admission cards given to the patients.

This is of special importance in those clinics with a large attendance, such as the medical, surgical, and children's clinics, for where these are located on different floors, the waiting room on such floor becomes largely a special waiting room for these clinics. In this plan easy supervision is combined with proximity of patients to the clinics in which they are to be treated.

Special attention must be given to those patients who come an hour or two before the physicians begin treatment. As they will not go away, and cannot be left standing outside, they must be admitted to the building. They may then be handled in one of two ways. They may be examined by the admitting officials and registered at once, and then sent to the regular waiting rooms to await the opening of the clinic. This would avoid the need for special waiting rooms and give more time to careful examination of the new patients, but it would also require the officials to go on duty long in advance of the regular hours. A second plan is to provide space in the main entrance hall, where these patients can wait until the hour of opening or until such time as the admitting officials begin the work of admission. The number of patients coming too early will vary in different localities, but can be regulated to a greater or less extent by continued admonition against the practice of early coming. This special waiting space will also be very serviceable, if not indispensable, in caring for an unusual crowd. The attendance at out-patient departments is often very irregular and at times the patients come in such large numbers that the admitting officials cannot examine them as they come and some provision must be made for the excess number. This special waiting space, if economy compels, may be part of the regular waiting space, if it be so arranged that the early comers may readily reach the admitting desk when the regular time for admission arrives.

Number, Arrangement, and Type of Seats

The number of seats needed will depend very much on the method of operation, which will be discussed on succeeding pages. The seating capacity is woefully inadequate in many out-patient departments, and a liberal provision for seats should be made. Where efficient work is done it is obvious that a large percentage of the patients treated in one-half day will be there at one time—it was found by actual count, in one such out-patient department, that the number of people seated at one time was from 85 to 90 per cent. of the number treated in that dispensary during the half day on which the count was made. Moreover, many patients are accompanied by friends or relatives; children are usually accompanied by their parents, who bring other children with them. Seats must be provided, therefore, for many people who are not patients. In children's clinics a fair estimate is two seats for each child in attendance as a patient. For the other clinics seats should be provided equal to the maximum number of patients treated in each clinic during each half day session.

Seats for the patients for each clinic should be arranged in a group near the clinic, and these groups should be separated from each other by a colored sign, which could be moved as the attendance varies in the different clinics. This arrangement requires no more seats than would otherwise be needed, and it will help to prevent confusion. By such an arrangement patients can more easily find their proper place, and fewer attendants will be required. Once seated, patients should not be required

to move until called to the examination room. If a single entrance to a group of seats is provided, and a single exit on the other side of that group nearest the examination room, the result will be that a large number of seats will not be occupied. The arrangement should be such that the vacant seats will be readily occupied by the patients as they come, and, to insure that the patients are treated in the proper order, they should be given a consecutive number by the registration clerk, which will be called for by the examining physician.

The seats provided should be of a substantial character, and not easily moved by the patients. They should not be fixed, as it will be necessary to move or tilt them in order to facilitate the washing and cleaning of the floor. A good type is a low bench, with solid seat, and, perhaps, solid back. These should be of a standard size, each possibly seating six persons, so that they could be available for different combinations and groupings if it should be desired to change the number of seats for any group of patients.

Sessions of the Clinics

It is obvious that the number of patients to be accommodated at one time in the various clinics will depend in a large measure upon the method of operating the out-patient department. Before plans are prepared these questions must be considered: (1) Should rooms be provided for the exclusive use of each clinic, or should some or all of them be used for one class of patients in the forenoon and another class of patients in the afternoon? (2) Should there be one, two, or three sessions a day for the treatment of some or all classes of cases?

In regard to using the same rooms for the treatment of different classes of cases at different times of the day, it may be said that it requires greater watchfulness to guard against infection when rooms for the treatment of skin diseases, genito-urinary cases, certain septic surgical cases, and tuberculosis are used the same day for the treatment of other patients, especially children. The opinion of physicians differ on this point, but the weight of authority seems to be against this practice. Also, the rooms designed for one class of patients are often not well adapted for the treatment of another class. In an out-patient department where several hundred patients are in attendance each day it is undoubtedly better to have rooms provided for the exclusive use of each clinic.

Assuming, therefore, that each clinic is to have its own rooms, there are still several plans of operation which affect the size and arrangement of treatment rooms. One plan is to have the building open only once a day and all classes of cases received. This would require a large building, which must stand unused most of the time. Another plan is to admit certain classes of cases in the forenoon and other classes in the afternoon, which would diminish the number of patients to be handled at one time and therefore require a smaller building. A third plan is to keep the building open both forenoon and afternoon for all patients, or at least for those classes of patients in which the attendance is large enough to warrant it. This plan seems preferable, for, as in the second plan, it requires a building only of moderate size and is continually in use. It is convenient for patients, as it affords them a choice of time; it also tends to secure a better class of physicians, since they are given a choice of forenoon or afternoon.

This plan may be modified by opening certain clinics in the evening also, for many men and women cannot leave their occupations to attend a clinic during the day. In one out-patient department the male attendance for a short period in certain clinics was increased 53 per cent. because the men in that district were out of work on account of a strike and thus had time to attend the clinic. In order to accommodate these patients an evening session is very desirable, especially for such clinics as the general medical and surgical, the gynecological, and the genito-urinary. The third session would not influence the size or plan of the building, and could be introduced when conditions justified it, or when the attendance at certain clinics became so large as to make it necessary.

Arrangement of Clinics

The number and character of clinics will depend on the direct needs of the district served by the out-patient department. In most large dispensaries certain clinics are usually maintained, as the children's clinic, general medical, general surgical, gynecological, genito-urinary, skin, eye, ear, nose and throat. To these other clinics are being added which have already demonstrated their usefulness, or whose necessity becomes more and more apparent year by year, as the orthopedic, the dental, the clinics for nervous and mental diseases, and the physical radio and hydro-therapy clinics.

In providing space for the various clinics care should be taken to avoid locating close together those having a very large attendance, as this would inevitably lead to overcrowding in that part of the building. It must also be kept in mind, however, that it is desirable to have as small a number of patients as possible dependent upon the elevator, and the upper floors should therefore be reserved for the clinics with the smallest number of patients. The largest number of patients would attend the general medical and children's clinics, and it is advisable that these should be located on the first floor, even though this might tend to produce congestion, because there would naturally be a greater number of officials and attendants on the first floor, and because it is inadvisable to have too many children make use of the elevator. The surgical clinic should be placed on the second floor, and the others located so as to secure, as nearly as possible, an equal distribution of patients over the whole building. Consideration should also be given to the special requirements of each clinic, such as quiet, and good light, where most needed.

In planning the rooms for each clinic one of three types may be chosen: the room may be made large, moderate in size, or very small. The large room enables two or three physicians to work at one time, with screens separating the patients; this affords ease of consultation between physicians, enables one man to handle all cases in an emergency, and makes it possible to use one room and its equipment for different purposes. The large room, however, does not afford the quiet necessary for certain examinations, nor the privacy desirable for all patients.

A single small room, large enough to hold merely the physician and his patients, has many advantages, and also some disadvantages if not carefully planned. The chief advantage is privacy, which is desirable for the patients, and enables the physician to do better work. The disadvantages are that small rooms require more space than larger ones; consultations between physicians are somewhat difficult; and the rooms are inelastic and cannot be altered as circumstances may require.

If the clinics are to be used for teaching purposes, however, the rooms should be of moderate size, about 9 x 14 feet. This has been found to be suited to the need of a physician or surgeon working under the observation of a small group of students. Even if the out-patient department is not organized essentially for teaching purposes a room of such size is not extravagant, facilitates work, and allows for the possibility of teaching being made a feature of the clinics at some future time.

General Medical Clinic

Owing to the large attendance at this clinic, from 40 per cent. to 50 per cent. of the total, it should preferably be located on the first floor. Good light is of less importance here than in other clinics, such as those for skin diseases and dentistry. The waiting-space may be common to both sexes, but there should be separate examination rooms for male and female patients. A room may be set aside for the treatment of stomach cases, and other specialization may be found desirable, both for teaching purposes and for attracting specialists in certain diseases.

Children's Clinic

The treatment of children's diseases has become a specialty, and a clinic for children should be maintained separate from that for adult medical cases. As a preventive agency in the development and spread of disease the children's clinic is of the greatest importance. Here, also, will be found the largest number of infectious cases coming to the dispensary, and special care should be taken to guard against the spread of such diseases.

Surgical cases, skin diseases, and other special cases among children may be treated in the clinics provided for adult cases, all children under seven years being treated in the female rooms, and children over seven in rooms according to their sex. One room in the children's clinic should be devoted to the treatment of babies. Diseases of infancy should be given special consideration here, and mothers instructed in feeding and general care of babies.

Surgical Clinic

In this clinic there should be a division for male patients and another for female patients. In each division there should be an operating room, somewhat larger than the ordinary treatment room. One small sterilizing room should be provided, and in each division rooms might be set aside for fracture cases, for the dressing of clean wounds, and for septic cases.

Gynecological Clinic

The careful examination and treatment of these cases require an operating room with equipment, and also a consultation room, where preliminary examination may be made. Owing to the character of these diseases it is especially advisable that only one patient at a time should be admitted for treatment.

In connection with this clinic a room should be devoted to obstetrics, where special treatment for such cases may be given, together with instruction in prepartum hygiene. The importance of this clinic in connection with visiting nursing has been pointed out elsewhere.

Genito-urinary Clinic

It is desirable to locate this clinic in such a way that the patients will come in contact with the patients of other clinics as little as possible. In addition to the treatment rooms, and rooms for the preparation of cases, a special laboratory for blood tests, etc., is desirable, but not absolutely essential. The preponderance of opinion seems to be that syphilitic cases should not be treated here, but sent to the skin clinic.

Dermatological Clinic

This clinic should be located where good light is available. One room for men and one for women will be necessary, and if syphilis is treated two additional rooms will be required.

Nose, Throat and Ear Clinic

As artificial light is largely used in the work of this clinic, it may be located where the natural light is insufficient for other clinics. One large room may be used for this clinic, separated by partitions into the desired number of compartments, one for each physician in attendance. In addition there should be a small operating room for more serious cases. Tonsils and adenoids may be removed in this clinic, or such cases may be sent to the hospital, especially if they are to be kept over night.

Eye Clinic

This clinic will require an examining room at least 20 feet in one dimension, for testing, and also an operating room and a dark room.

Dental Clinic

The relation of defective teeth to other disorders is well recognized, and medical men are attaching more and more importance to the proper care of the teeth, especially in children. A dental clinic with two rooms should be provided.

Clinic for Nervous and Mental Diseases

Such clinics have been greatly neglected in the past and their importance much underestimated. This is shown by the records of the East Side Clinic for Mental Diseases, at 295 Henry Street, and by records of similar clinics at Cornell, Vanderbilt, Bellevue, and others. Such clinics would result in a better knowledge of mental diseases in their early manifestations, and would promote the discovery and treatment of many mental cases in the early and more curable stages. At present too many cases of insanity do not come under treatment until they are well developed.

Orthopedic Clinic

The correction of deformities by means of special apparatus and exercise is a very important branch of modern surgery which can be carried on successfully in the out-patient department. The necessary rooms should be provided for this work, and may well be located in the basement.

Hydro-therapy Clinic

The great benefit to many cases, particularly nervous diseases, of therapeutic treatment makes such a clinic of much importance in the organization of an out-patient department. The entire equipment can be placed conveniently in the basement.

Physical Therapy Clinic

Two rooms for baking apparatus and two for physical massage are necessary for this clinic. This is of special importance in the organization of the dispensary, as it enables the physicians and surgeons to secure for the patients special treatment necessary for the complete cure of the disease treated.

Radio-therapy Clinic

A room with apparatus for radio-therapy should be provided, for reasons similar to those above stated.

Contagious and Communicable Diseases

1. Whooping-cough

Increasing attention is being devoted to the treatment and the prevention of whooping-cough, recent studies by United States public health officials and others having shown the large rate of incidence and death in this disease. It is advisable, therefore, that there should be an isolated clinic devoted to the treatment of whooping-cough cases, since in many instances the early stages of this disease can be effectually treated in an out-patient department.

2. Vaginitis

The infectious nature of this disease has led many surgeons to recommend separate rooms for its treatment in an out-patient department, and this has been done in several instances, with beneficial results. The clinic for the treatment of vaginitis should be one of the isolated clinics.

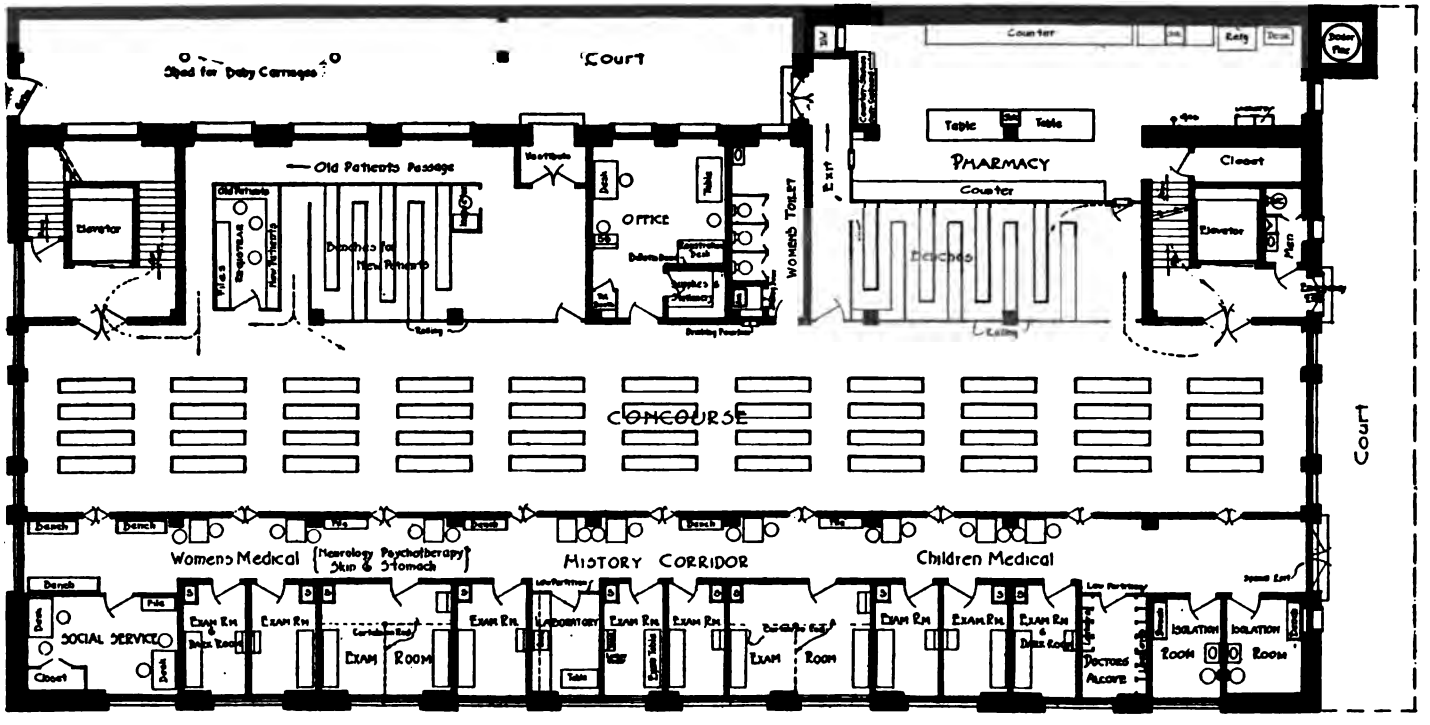
3. Tuberculosis

Tuberculosis should be treated strictly as an infectious disease, in order to impress upon patients its serious character. The rooms for this clinic, therefore, should not be used for the treatment of other diseases, and it is to be preferred that they be entirely separate from the other clinics and a separate entrance provided. In estimating the number of rooms for this clinic allowance should be made for the increase in attendance that will follow effective treatment. The roof of the out-patient department may be so constructed that it could be utilized as a day camp for tuberculous patients.

SUPPLEMENT

To illustrate the foregoing principles and considerations there are submitted herewith floor plans adapted to a typical New York City corner lot, restricted on two sides by buildings. The purpose of the plans primarily is to show the grouping of rooms; the relation of rooms to the waiting space; the proportion of waiting space and rooms; the relative sizes of rooms used for different purposes.

The plans are not drawn for a particular hospital, but, taken in connection with the material in the memorandum, they should be of service in designing such a department for any public hospital.



FIRST FLOOR PLAN -

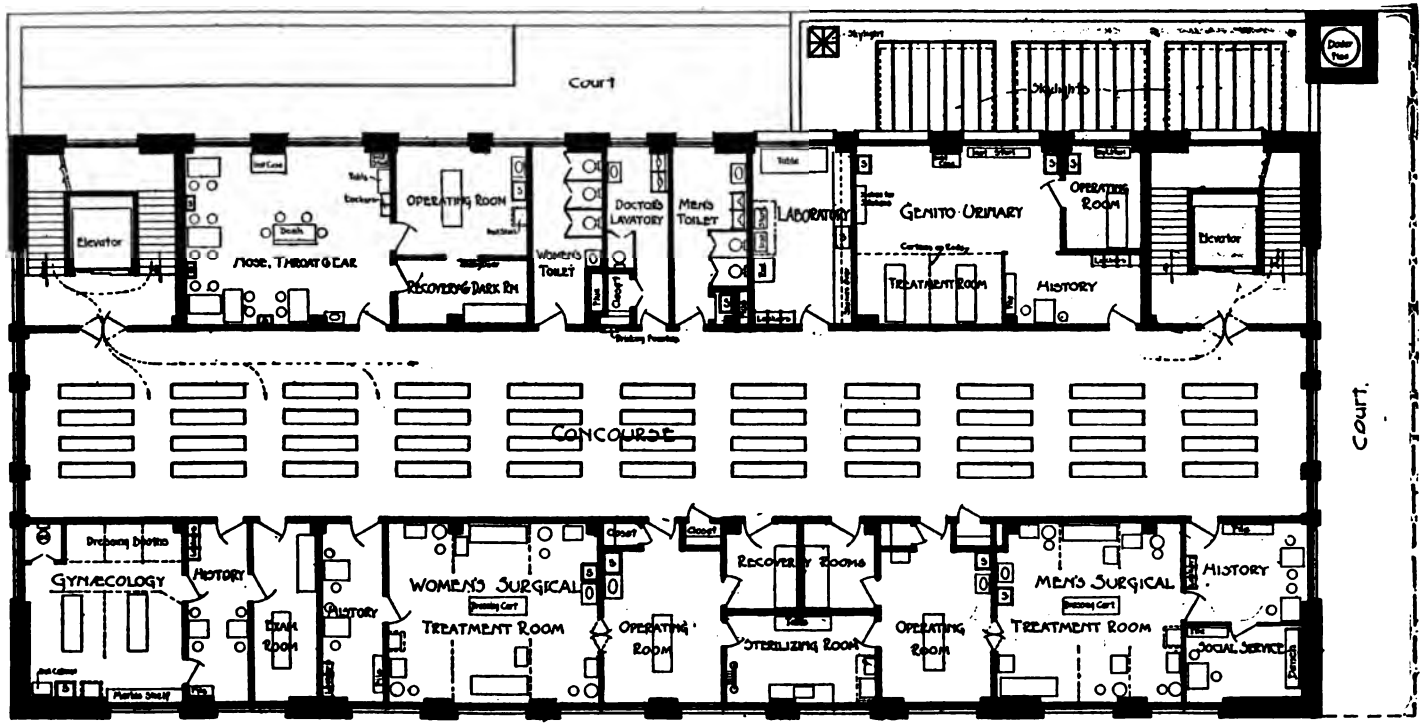
Scale: 10 feet

·OUT-PATIENT · DEPT · FLOOR · PLAN ·

·suggested by ·

· DR S.S GOLDWATER ·

To be built on restricted site with buildings adjacent



SECOND FLOOR PLAN

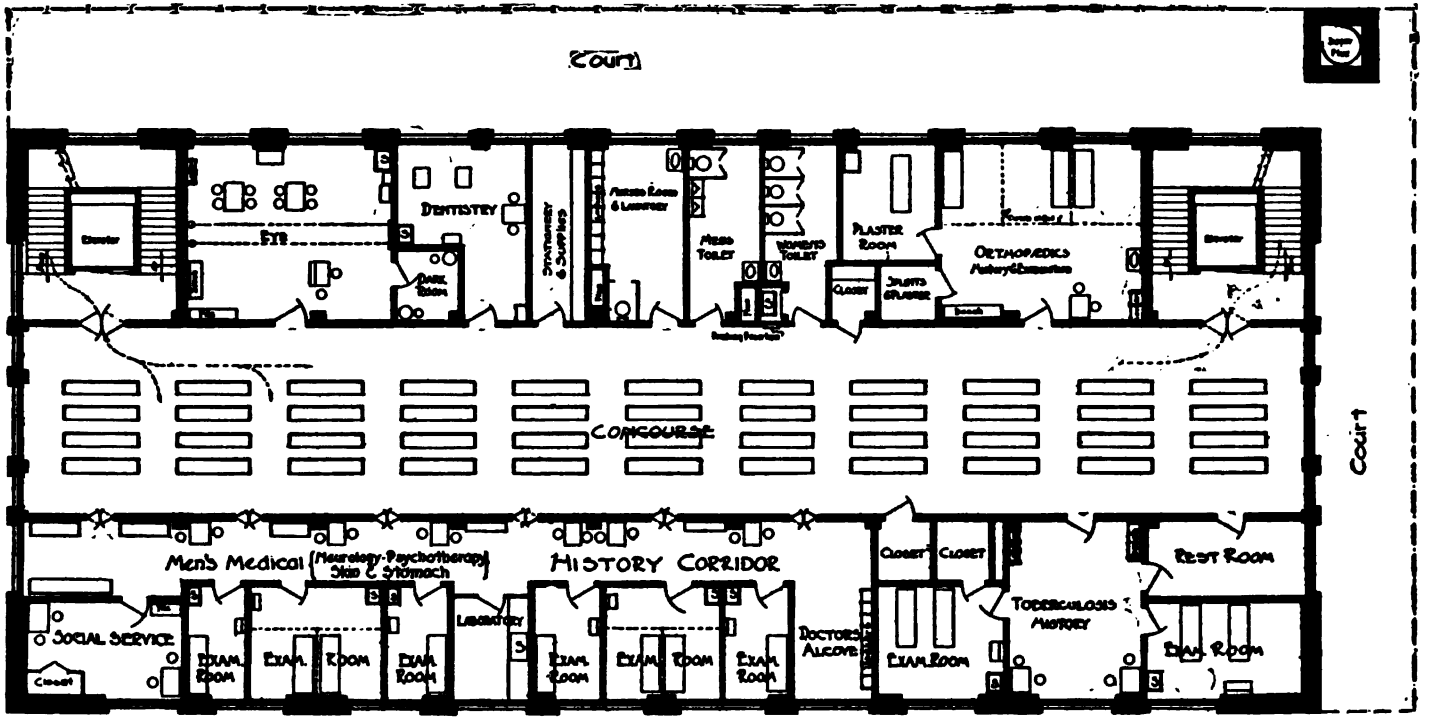
Scale 10 Feet

OUT-PATIENT DEPT. FLOOR PLAN

Suggested by

DR S. S. GOLDWATER

To be built on restricted site with buildings adjacent



"THIRD FLOOR PLAN"

Scale 10 Feet

OUT-PATIENT DEPT FLOOR PLAN

suggested by

DR S S. GOLDWATER

To be built on restricted site with building adjacent

APPENDIX

SUGGESTED RECORDS

Patients' History Cards

The patient's history cards should be of flexible cardboard, 8 x 10 inches, to facilitate filing and removal. There should be special cards for each clinic, with the items appropriate to the diseases treated therein, and each clinic history card should have its own color corresponding to the color of admission card. The items for the social history would remain the same on all.

The following specimens indicate what would be adequate for the general medical and gynecological clinics. (Cards for the other clinics would have appropriate wording, and diagrams to mark the location of lesions, etc., should be printed on the tuberculosis cards and on any others where they would assist in a clear description of the case.)

CASE No.....

OUT-PATIENT DEPARTMENT

Date.....

Name..... Age.... Mar. State..... Nativity.....

Address: Street..... No..... Floor..... Care of.....

..... How long at present address.....

Previous address..... Occupation.....

.....

Home: Number of Rooms.....Sink..... Toilet..... Art. Heat.....

Names of Members of Family	Age	Diseases	Work	Income
1	....	.....	.....	.....
2	....	.....	.....	.....
3	....	.....	.....	.....
4	....	.....	.....	.....
5	....	.....	.....	.....
6	....	.....	.....	.....

Total Income, ...

Rent Paid..... Insurance..... Charitable Relief.....

GENERAL MEDICAL CLINIC

Dr. ..... DIAGNOSIS, ...
Complications. .....
(NOTE: Whenever possible use X or O to denote the presence or absence of a characteristic.)

Family His.: Tbc.... Neur.... Arth.... Canc.... Nephr.... Syph.....
Patient's His.: Tbc.... Diph.... Scar. F.... Typh.... Gout.... Rheum.... Malar.... Pneu....
Habits: Tea.... Cups.... Coffee.... Cups.... Alch.... Tob.... S. or C.....
Char. of food.....Mastication.....
Pres. hist. began..... Onset: Gradual.... Sudden.... Free inter....
Prob. cause..... Symptoms changed .....
Headache.... Char..... Location..... Time of.....
Vertigo..... Nervousness..... Drowsiness..... Bad taste..... Appetite.....
Thirst.... Dysphagia.... Vomit.... of blood..... Feeling of fullness..... of weight.....
of discomfort..... Time of.....
Heartburn..... Time of.....
Pain.... Location..... Time of..... Duration.....
Affected by position.....by food or drink.....Relieved by.....Sympts. ref. to circ. syst..... to resp. syst..... to nerv. syst.....
to g. u. syst..... Stools reg..... Const..... Diar..... Color.....
Blood..... Mucus..... Gen. health and strength..... Loss of weight..... Sleep.....

Remarks: .....

Phys. exam.: Nourish..... Develop..... Weight..... Teeth..... Tongue ..... Pupils: Rt..... Lf..... React. light..... Accom..... M. M.....
Color..... Anemic..... Glands..... Pulse to min..... Irreg. in f.....
Irreg. in r..... Tension volume..... Vessel not thickened..... B. P..... M. M.....
Heart: P. M. I. in..... i. s..... inch. from M. S. L.....
Sounds.....
Lungs: Expansion, rt..... lf..... Percus. and auscult.....
Resp..... to min.....
Abdomen:.....Liver..... Spleen.....
Stomach: ..... Position..... Tenderness..... Tumor.....
Bowels..... Rectum.....
Nervous System: ..... Reflexes.....
Test Meal.....
Urine.....
Blood.....
Feces.....
Treatment.....

(Reverse Side)

SUBSEQUENT VISITS [1]

Date	Symptoms and physician's signature	Treatment
.....	.....	.....
.....	.....	.....

[1] Additional sheets, if necessary, for subsequent visits could be attached to the original card. The wording of the reverse side and the additional sheets would be the same for the history cards of all the clinics.

CASE NO.....

OUT-PATIENT DEPARTMENT

Date.....

Name..... Age.... Mar. State..... Nativity.....
Address: Street..... No..... Floor..... Care of.....
.....How long at present address.....
Previous address..... Occupation.....
.....
Home: Number of Rooms..... Sink..... Toilet..... Art. Heat.....

Names of Members of Family	Age	Diseases	Work	Income
1.....	....	.....	.....	.....
2.....	....	.....	.....	.....
3.....	....	.....	.....	.....
4.....	....	.....	.....	.....
5.....	....	.....	.....	.....
6.....	....	.....	.....	.....

Total Income, ...

Rent Paid..... Insurance..... Charitable Relief.....

GYNECOLOGICAL CLINIC

Dr..... DIAGNOSIS.....
Complications.....
(NOTE: Whenever possible use X or O to denote the presence or absence of a characteristic.)
Family His.: Tbc..... Neur..... Arth..... Canc..... Neph..... Syph.....
Patient's His.: Tbc..... Diph..... Scar. F..... Typh..... Gout.... Rheum.....
Malar..... Pneum..... Grip.....
Operations: Menses began at .... yrs.; Every .... weeks; Duration ..... Flow
..... Painful ..... Last period ..... Preced. period.....
Married..... Yrs.... Children..... Oldest ..... Youngest .....
Miscar.....
Labors and puerperia: Phys. ex vagina:..... Urethra..... Bartholin glands
.....
Perineum: Rupture..... 1st degree..... 2d degree..... 3d degree.....
Uterus: Cervix lacerated.....
Position: Antipledia..... Retroflexion..... Prolapse.....
Ovaries: Prolapsed..... Cystic..... Retrodisplaced.....
Fallopian tubes.....
Test: Urine..... Blood.....
Treatment:

Social Service Records

The visit to the home of the patient, whether merely to investigate the financial condition or to administer prescribed treatment, should result in securing a more complete account of the patient's social environment than was possible at the admitting desk. The card on which the visiting nurse enters her data should be itemized as fully as possible, to save time in history taking. It should have, in addition, space for recording the nursing done in the home, and any other assistance given. The sheet should be of the same size as the original Social and Medical History Card, so that it may be attached to, and filed with that card, if deemed desirable.

SOCIAL SERVICE BUREAU

CASE NO.....
OUT-PATIENT DEPARTMENT
Original Case No.....
Clinic.....
DIAGNOSIS.....

Name..... Age..... Date.....
Referred by.....
Address: Street.....No..... Floor..... Care of.....
House: (Ten. Apt. Lodg. H.)..... Number of Stories.....
Number of Families..... Gen. cond. of bldg.....
Cleanliness.....
Home: Number of rooms..... Lt..... Dark..... Dim..... Rooms used for sleeping.....
Cleanliness: Sink..... Toilet..... Roof available..... Art. heat.....
The Family: Adults..... Children..... Boarders..... Who cares for pt.....
Family cond.: (neat, careless, dirty)..... Other cases in family:.....

Names of Members of Family	Age	Diseases	Work	Income
1.....	....	.....	.....	.....
2.....	....	.....	.....	.....
3.....	....	.....	.....	.....
4.....	....	.....	.....	.....
5.....	....	.....	.....	.....
6.....	....	.....	.....	.....

Total Income.....

Rent paid..... Insurance..... Charitable relief.....
Deviations from history given to admitting officer: .....
Recommendation of Visiting Nurse: .....
Assistance secured by Social Service Bureau: .....

(Reverse side)

HOME NURSING:

Prescription of O. P. D. doctor:
Date..... Condition..... Treatment.....

Admission Cards

1. The admission card should be of stiff cardboard, about 2 x 3½ inches, and of a different color for each clinic. A difference in shades would help to distinguish cards of the same clinic, to be used for different days or different sessions. For instance, if red were the color for the general medical clinic, a dark red would be used for Monday, Wednesday, and Friday clinics, and a light red for the Tuesday, Thursday, and Saturday clinics. The same sort of differentiation could be used between morning and afternoon sessions, so that the admitting attendant could immediately recognize patients appearing at wrong hours and refuse to admit them, except for some special reason. It is advisable that a nominal fine be imposed for the loss of a card. The penalty might be rescinded at the discretion of the admitting officer, but the fact of a fine being possible would make the patients more careful and would prevent the loss of time entailed in reissuing cards. Following is a specimen of the facts that should appear upon the printed card:

ADMISSION CARD CHILDREN'S CLINIC

NO. ——

CHILDREN'S CLINIC

Dr.

Mondays, Wednesdays, Fridays
9.30 to 11.30

ALWAYS BRING THIS CARD WITH YOU

A fine of 10c. will be imposed for loss of card

(*Reverse Side*)

OUT-PATIENT DEPARTMENT

Name:
Address:

Section 296, Chapter 55,
Consolidated Laws.

"Any person who obtains medical or surgical treatment on false representation from any dispensary licensed under the provisions of this act shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not less than ten dollars, and not more than two hundred and fifty dollars."

Imprisonment until fine be paid may be imposed. Code Crim. Pro., Section 718.

2. In addition to the patient's card, which would be in the patient's possession, there should be an admission check, which would be simply a small card, 1 x 2 inches, colored to correspond to the patient's card, and containing only the name of the clinic and the number of the patient, issued in order of appearance. These cards would be issued by the registration clerk to every patient at each visit, and would serve to keep a regular order of admission of patients to the clinic rooms. The registration clerk would keep a record of the number of new and old patients admitted to each clinic room at each session.

Form for Transfer of Patients from Hospital to Out-Patient Department

The following specimen shows a form for this purpose:

.....Hospital

Transfer to Out-Patient Department

Name..... Hospital No.....

Address..... Date.....

Diagnosis.....

Admitted to Ward..... Transferred to Ward.....

Discharged to Out-Patient Department for.....

Dr. .....

Approved Supt. .....

Form to be returned from O. P. D.

Diagnosis..... Hospital No.....

Remarks: .....

.....

.....M. D.

(Doctor treating patient in O. P. D.)

O. P. D. No. .....

Stub .....Hospital

Transfer to Out-Patient Department.

Name..... Hospital No..... Date.....

Referred to..... Clinic.....

Reply Received....., 191....

.....M. D.

(To be retained in the hospital.)

Form for Transfer of Patients of Out-Patient Department to the Hospital

The following specimen shows a form for this purpose (sheet should be colored corresponding to the color used by the clinic from which it is issued):

OUT-PATIENT DEPARTMENT

Transfer to Hospital or to Clinic

No. ..... Date.....

Name..... Address.....

From.....Clinic

To..... { Clinic / Hospital

Under treatment here for.....

Referred for { additional diagnosis / treatment

Remarks: .....

.....M. D.

To be returned to O. P. D.

O. P. D. No..... Hospital No. .....

To.....Clinic.....

Diagnosis.....

Remarks: .....

.....M. D.

Stub Out-Patient Department

No.....Date.....Name.....

Referred to.....for.....

Reply received....., 191.....

.....M. D.

(To be retained in clinic or O. P. D.)

Form to Accompany Laboratory Specimens

The physician or surgeon who sends specimens of blood, sputum, etc., for analysis, should send with each specimen a slip similar to the following:

OUT-PATIENT DEPARTMENT
Genito-urinary Clinic

Dr. ..... Date.....
Patient's name..... Diagnosis.....

1st Specimen	Blood	To be
2nd "	Urine	Examined
3rd "	Sputum	for
	Pus (side)	
	Gastric Contents	
	Fæces	

Laboratory Report.....
.....
.....
.....
Clinical Microscopist

Form to Accompany Patient to the X-Ray Department

The following specimen shows a form for this purpose:

OUT-PATIENT DEPARTMENT
General Surgical Clinic

Patient's name..... Date.....
Referred by Dr. ..... Diagnosis.....

To X-RAY DEPARTMENT

to {fluoroscope / skiagraph} the.....
(Part of body)

Special point for consideration by the X-ray operator.....
.....
Patient was skiagraphed or fluoroscoped on.....
Reason for this examination.....
What kind of dressings, bandages, splints or packings has patient?.....
.....
Can these be removed?.....

Form for Referring Cases from Clinics to the Social Service Bureau

The following specimen shows a form for this purpose:

OUT-PATIENT DEPARTMENT
Children's Clinic

Date.....
Name of Patient..... Case No. .....
Address..... Diagnosis.....
Remarks.....
.....
Dr. .....

Form for Patients Needing Special Dressings or Examination

It will frequently happen that a patient whose injury has been dressed, or of whom an examination has been made, will need an additional dressing or reëxamination for particular symptoms earlier than the time when the physician or surgeon who originally treated the patient is to return. For instance, a surgeon who attends his clinic on Monday, Wednesday, and Friday, may on Monday treat a fracture which, in his opinion, would require redressing on Tuesday. There should be a form to accompany the patient on this special visit, as follows:

OUT-PATIENT DEPARTMENT

General Surgical Clinic

Date.....

Please {dress / examine} this case.....day

....., 191....

Remarks.....

Dr. .....

Statistics

The Registrar would keep in a daily loose-leaf register account of the number of patients admitted to each clinic, according to diagnoses, and a general account according to clinics. These figures would be secured from the record cards, which would be returned to him from the clinic rooms before distribution to the files. At the end of the month he would send the sheets, with their summaries, to the Superintendent, who, after inspecting them, would return them to him for filing. The summaries would be combined into an Annual Report. (Suggested forms are shown on pages 515 and 516.)

Monthly Record of Attendance. Out-Patient Department. General Medical Clinic.

Month.....

Diagnosis	1								2								Successive columns provide for all the days in the month.	Summary											
	New Patients				Total Number Visits				New Patients				Total Number Visits					Total Number of New Patients				Total Number of Visits				Average Number of Visits per Patient			
	M.	F.	Ch.	Total	M.	F.	Ch.	Total	M.	F.	Ch.	Total	M.	F.	Ch.	Total		M.	F.	Ch.	Total	M.	F.	Ch.	Total	M.	F.	Ch.	Total
Bronchitis																													
Constipation																													
Etc.																													
Totals																													

Annual Record of Attendance. Out-Patient Department. General Medical Clinic.

Year.....

Diagnosis	January								February								Successive columns provide for all the months in the year.	Summary											
	New Patients				Total Number Visits				New Patients				Total Number Visits					Total Number of New Patients				Total Number of Visits				Average Number of Visits per Patient			
	M.	F.	Ch.	Total	M.	F.	Ch.	Total	M.	F.	Ch.	Total	M.	F.	Ch.	Total		M.	F.	Ch.	Total	M.	F.	Ch.	Total	M.	F.	Ch.	Total
Bronchitis																													
Constipation																													
Etc.																													
Totals																													

Monthly Report of Attendance.

OUT-PATIENT DEPARTMENT

Month.....

	1st		2d			Summary		
Clinics	New Patients	Total Number of Visits	New Patients	Total Number of Visits	Successive columns provide for all the days in the month	Total Number of New Patients	Total Number of Visits	Avge. Number of Visits per Patient
Gen. Med. Male								
Gen. Med. Female								
Gen. Children								
Gen. Surg. Male								
Gen. Surg. Female								
Gynecological								
Skin								
Genito-urinary								
Etc.								
Total								

Annual Report of Attendance.

OUT-PATIENT DEPARTMENT

Year.....

	Jan.		Feb.			Summary		
Clinics	New Patients	Total Number of Visits	New Patients	Total Number of Visits	Successive columns provide for all the months in the year	Total Number of New Patients	Total Number of Visits	Avge. Number of Visits per Patient
Gen. Med. Male								
Gen. Med. Female								
Gen. Children								
Gen. Surg. Male								
Gen. Surg. Female								
Gynecological								
Skin								
Genito-urinary								
Etc.								
Total								

The head of the Social Service Bureau would report monthly to the Superintendent on the following form, the summary of which would comprise the Annual Report:

MONTHLY REPORT OF SOCIAL SERVICE BUREAU.

Month..... .....Hospital
Total number of cases investigated.....
Number of cases visited at home.....
Number of cases nursed at home.....
Total number of visits for nursing.....
Number of cases for which charity relief was obtained.....
Number of cases treatment refused.....

ANNUAL REPORT OF SOCIAL SERVICE BUREAU.

Year..... .....Hospital
Total number of cases investigated.....
Number of cases visited at home.....
Number of cases nursed at home.....
Total number of visits for nursing.....
Number of cases for which charity relief was obtained.....
Number of cases treatment refused.....

From the register signed by the members of the medical staff at the time of arrival and departure, the Registrar would compile the following Report of Attendance of Doctors:

MONTHLY REPORT.
ATTENDANCE OF DOCTORS.

Month.....

Clinics	Dr.	Pos.	Scheduled Attendance		Number of Days Present	Number of Hours Present
			Days	Hours		
Medical, Male.....	Dr. S.					
	Dr. P.					
	Dr. C.					
	Dr. F.					
Medical, Female...	Dr. S.					
	Dr. P.					
	Dr. C.					
	Dr. F.					
Medical, Children..	Dr. S.					
	Dr. P.					
	Dr. C.					
	Dr. F.					
Surgical, Male.....	Dr. S.					
	Dr. P.					
	Dr. C.					
	Dr. F.					
Surgical, Female...	Dr. S.					
	Dr. P.					
	Dr. C.					
	Dr. F.					
Gynecological.....	Dr. S.					
	Dr. P.					
	Dr. C.					
	Dr. F.					
Etc.						

3. SICKNESS IN THE HOME AND PROPOSED HEALTH CENTER.

THE INVESTIGATION

Study of Sickness in the Home in Certain Districts of New York City

Necessity for Such Study

One of the duties that the City of New York has assumed is the care of the public health. Up to the present time, except for the hospitals supported entirely or in part by the City funds, the work has been preventive rather than curative. The Divisions of Contagious and Communicable Diseases of the Department of Health receive and disseminate to interested parties reports of such diseases. In addition, they employ district inspectors and nurses to visit cases of such diseases when not under the care of a private physician, in order to see that proper quarantine is maintained and that the quarters are fumigated upon the termination of each case. Actual care of the sick in their homes for these or any other diseases has not yet been attempted by the City. So far as it has been done it has been left to the initiative of private charities.

The basis of this study is the assumption that in order to control disease it is necessary for the City to have at least an approximate knowledge of the amount and character of sickness existing during any year. To prescribe adequate measures of relief, or even of safety, without such knowledge would be exceedingly difficult, if not impossible. The present agencies for obtaining this information are inadequate. The Department of Health has no means of ascertaining the existence of contagious and communicable diseases, except from the reports of hospitals and private physicians, and although a legal penalty is attached to the failure to report such a case, it is well known that there are many derelictions. In addition to these there are numerous instances where, because of the mildness of the attack, a physician is not called in, and practitioners agree that the danger of infection from these unattended cases is very great. For all other diseases no attempt is made to discover their prevalence or effect.

Method of Inquiry

Several methods of determining this question were considered before adopting the one pursued.

A house-to-house canvass over the entire City could not be attempted, owing to the expense, and it was decided that it would be impracticable to circularize all the physicians of the city; first, because many of them would have no time or inclination to answer circular letters of inquiry, and of those who did, many would lack complete records of their cases; second, because by this method, all those cases in which the services of a physician were not used would be missed, these latter being the ones it was particularly desired to reach. Charity organizations and relief societies could give information of only those cases in which relief was asked for, which would be an inconsiderable part of the total.

It was finally determined to make a careful calculation of sickness at home in two sections of the City and supplement this by a house-to-house

canvass of a few blocks within the same districts, and an intensive study of some one disease.[1] The special benefit of such a method lay in the possibility of selecting particular sections where, because of unfavorable living conditions, or the poverty or ignorance of the inhabitants, it would seem especially necessary that the City assume control. The additional information secured by the house-to-house canvass and the study of one disease would serve to further illuminate the situation.

The calculation was made on the basis of deaths from zymotic and certain other preventable diseases as recorded in the Department of Health. The Bureau of Records classifies these deaths by wards. During the year 1910, the deaths from such diseases occurring in institutions were listed for the wards in which the institutions were situated, so that by consulting the records of the several institutions to discover the number of deaths of particular diseases occurring in them, and deducting this number from the total reported by the Department of Health, the number of deaths occurring at home was ascertained. For instance, in the Seventh Ward 90 deaths were caused by pneumonia during 1910, and as 68 of these were in institutions, 22 were listed as having occurred at home. Using these figures and the death rate of this disease as established by competent authorities from a large number of cases, it was possible to arrive at an estimate of the number of cases of pneumonia that ran their course in the homes of the Seventh Ward residents in 1910.

After the year 1910, the Health Department listed the deaths having occurred in institutions from certain diseases for the ward in which the deceased resided previous to death. This method of recording deaths by residence rather than by institutions made it impossible to ascertain the number of deaths having occurred at home without consulting the individual death certificates. It is possible, however, to estimate with a considerable degree of accuracy the number of deaths having occurred at home by using the statistics of 1910 as a basis and adding thereto a percentage of increase to account for the probable number of deaths in 1911.

Districts Studied

Two sections in Manhattan were selected for study. One was designated as Lower East Side District, within the area bounded on the east by the East River, on the north by East Fourteenth Street, on the west by Fourth Avenue to Houston Street and by Broadway from Houston Street, on the south by Park Row, Spruce Street and Ferry Street; comprising the 4th, 6th, 7th, 10th, 11th, 13th, 14th, and 17th Wards. The other section was designated West Side District, within the area bounded on the west by the Hudson River, on the north by West Fortieth Street, on the east by Sixth Avenue, on the south by West Fourteenth Street; comprising the 16th and 20th Wards.

The population of the Lower East Side District in 1910 was 621,339, an average density of 515 per acre. This means that 26.7 per cent. of the entire population of Manhattan is congregated in this portion, although it is only 9.4 per cent. of the area. The population is exceedingly diverse in point of nationality and in other characteristics; such as religion, literacy, native customs, etc. In a locality receiving annually so large an influx of immigrants as this a lack of knowledge of American institutions must be a prominent feature. Ignorance of personal sanitation must also be present.

[1] This last idea was later abandoned because of its infeasibility.

The West Side District is of a different type. The area selected is smaller, about 6.3 per cent. of Manhattan, and contains 5.5 per cent. of the entire population, an average density of 163 per acre. The people here are largely native Americans, a considerable number having been born in the district where they reside. There are many features here, such as the Tenderloin District, that make it interesting for a study of disease conditions.

Sickness Based on Health Department Statistics

Lower East Side District

The general estimate indicates that there were about 145,236 cases of sickness in this section during 1910—234 per 1,000 of population. Of these, 89.4 per cent. were treated at home and 10.6 per cent. in institutions. The 129,771 cases at home produced a total of 3,604,900 days of sickness, about ten times as many as for the corresponding period in hospitals.

TABLE I.

SICKNESS IN A LOWER EAST SIDE DISTRICT IN 1910.

Diseases.	Actual Number of Deaths in Institutions.	Actual Number of Deaths in the Homes.	Estimated Number of Cases in Institutions.	Estimated Number of Cases in the Homes.	Estimated Number of Days of Sickness in the Homes.	Estimated Number of Days of Sickness in Institutions.	Estimated Number of Cases in the Homes and Institutions.	Estimated Number of Cases in the Homes and Institutions in 1911.
Typhoid Fever	16	28	172	306	15,300	5,160	478	460
Scarlet Fever	31*	127	485	2,000	96,000	16,975	2,485	1,484†
Diphtheria	43	216	478	2,400	72,000	11,472	2,878	2,144
Pneumonia	95	530	465	2,600	100,440	9,758	3,065	2,740
Broncho-pneumonia	57	730	232	2,980			3,212	2,850
Cerebrospinal Meningitis	14	38	50	136	1,360	400	186	157
Measles	7	76	466	5,066	126,650	8,990	5,532	6,534
Whooping-cough	5	34	167	1,133	39,650	4,175	1,300	1,300
Diarrhœal Diseases	95	685	4,750	34,250	342,500	38,000	39,000	28,800
Pulmonary Tuberculosis	53	718	1,450‡	3,900	936,000	174,000	5,350	4,172
Other Diseases	541	3,680	6,750	75,000	1,875,000	101,250	81,750	88,780
Total	957	6,862	15,465	129,771	3,604,900	370,180	145,236	139,421

1 of every 4 of the population was sick.
89.4 per cent. of all cases of sickness were cared for at home and 10.6 per cent. were in institutions.
* This estimate was based on the average percentage of cases of typhoid fever and diphtheria that are taken to hospitals.
† The ratio used in estimating the 1910 cases was not used for 1911, as there was an epidemic of scarlet fever in this section during 1910.
‡ The basis of this estimate was that the ratio of the number of deaths occurring in this district bore the same ratio to deaths in hospitals as the ratio of the number of cases of tuberculosis in this district bore to the number in the entire City. The other basis was not used because the deaths from this disease at home represent a large number of cases that were in institutions at some time previous to their death.

Typhoid fever caused 44 deaths in this district during 1910, of which 16 were in institutions and 28 at home. The death rate of this disease, as determined from over 25,000 cases in large cities of America and Europe, is 9.3 per cent. The calculation, therefore, is that there were over 300 cases of typhoid, or 65 per cent. of the total, at home and about 172, or 35 per cent., in institutions; a total of more than 470. As the charts of the Health Department show only 271 cases reported from this section dur-

ing 1910 the conclusion is that more than 30 per cent. of the cases were not reported to the Department. This is a conservative estimate, since the 9.3 per cent. death rate is taken largely from the statistics of hospitals, where, because the more severe attacks of typhoid are cared for in hospitals, the rate would be higher than in the general run of cases. Osler, in his "System of Medicine," puts the death rate for typhoid not in hospitals as low as 5 per cent. The 5 per cent. rate would mean that there were 560 cases of typhoid in the homes in this district in the year 1910.

Using the first estimate, however, in the more than 300 cases in the homes, it was, of course, impossible to discover at what stage a physician was called in, if at all. How much of the illness from this disease could have been prevented, or, at least, modified in intensity by adequate City supervision is a question of deep significance. "Too often," says Dr. Thos. McCrae, speaking of the private physician with a typhoid patient, "he does not realize his own responsibility, and is thoroughly satisfied if he brings the patient well through the attack, heedless of the danger to the community." Of more importance, however, is the fact of the large number of cases not reached by any physician.

There were 158 deaths caused by scarlet fever in the Lower East Side District, of which 31, or 19 per cent., were in institutions, and 127, or 81 per cent., at home. At a death rate of 6.4 per cent., a rate determined by a study of statistics bearing on over 133,000 cases from private and hospital practice in New York, Boston, and London, these 127 deaths meant that there were about 2,000 cases of scarlet fever in the homes in this section during 1910. The duration of this disease is from 34 to 48 days, so that according to this estimate there were from 68,000 to 96,000 days of care and attendance needed in this section for scarlet fever alone. The danger lies in the fact that this necessary supervision is not given; that there are a great many cases dismissed from the superficial care of ignorant or preoccupied relatives before desquamation has been completed, a period when the patient is of greatest danger to the community.

There were 216 deaths from diphtheria, or 84 per cent., at home in this district in 1910, and 43, or 16 per cent., in institutions. The average death rate of this disease in New York during the past ten years has been 9 per cent. On the continent of Europe, according to Prinzing's "Medizinische Statistik," the rate is much higher, 13.8 per cent., but this probably is due to the fact that there is not as wide a use of the diphtheria antitoxin there as here. Using 9 per cent. as the death rate of New York City, the 216 deaths meant that there were about 2,400 persons ill in their homes from this disease in the Lower East Side District, which would be equal to about 27 per cent. of the total number reported from the entire Borough of Manhattan. On the basis of an average duration of 30 days this estimated number of cases resulted in about 72,000 days of sickness.

Pneumonia and broncho-pneumonia together caused 1,412 deaths in this section. Of these, 95 died of pneumonia in institutions, and 57 of broncho-pneumonia, so that there were 530 deaths of pneumonia and 730 of broncho-pneumonia in the homes. A comparative study of over 525,000 reported cases in American and European countries shows a death rate of 20.4 per cent. for pneumonia and 24.5 per cent. for broncho-pneumonia. These rates have remained almost stationary during the past 15 years. There were, therefore, about 2,600 cases of pneumonia, 85 per cent. of all, in the homes in this section during 1910, and about 465, or 15 per cent., in institutions; a total of 3,065. There were about 2,980 cases of broncho-

pneumonia, or 93 per cent., in the homes, and 232, or 7 per cent., in institutions; a total of 3,212. This estimate of 5,580 cases in the homes meant from 55,800 to 100,000 days of sickness, based upon the usual duration of from 10 to 18 days. Overcrowding and bad ventilation, hunger and cold are strong predisposing causes. Unhygienic conditions in general increase both the number of cases and the duration of the disease. The United States census report shows that whites of foreign birth are much more frequently attacked by these lung diseases than native whites. That all these factors are active in the Lower East Side District is evidenced by the fact that the number of deaths here from pneumonia and bronchopneumonia was 28 per cent. of the total for Manhattan.

Of the 7,835 deaths in this district during 1910, 3,394 were of children under 5 years of age, a proportion of 43 per cent. of the total. For the entire City, exclusive of this section, the proportion of deaths of children under 5 to the total number of deaths was 30 per cent. This extraordinarily large death rate for children in the Lower East Side District makes especially interesting a study of measles, whooping-cough, and infantile diarrhœa in this section, these being the principal diseases of childhood.

There were 83 deaths caused by measles in this section, of which 76 were at home and 7 in institutions. The average death rate in New York for this disease is 2.5 per cent., but this is evidently too high, as it is based on reported cases only. Prinzing, in his "Medizinische Statistik," gives 1.5 per cent., which would seem more nearly correct. At this rate it was estimated that there were over 5,500 cases of measles in this section, or 38 per cent. of the total number reported from Manhattan. The cases in the homes, estimated at more than 5,000 cases, or 92 per cent. of all, produced a total of at least 125,000 days of sickness.

Whooping-cough caused 39 deaths in this section, of which 5 were in institutions. During normal periods the death rate of this disease is 3 per cent., which means that there were over 1,100 cases of whooping-cough in the homes, or 88 per cent. of all, and about 170, or 12 per cent., in institutions; a total of about 1,300 cases. With an average duration of 35 days, this estimated number of cases caused nearly 40,000 days of sickness at home in this section. The terrific virulence of whooping-cough when not under control (Kutlinger reports a death rate of 48 per cent. during an epidemic) would seem to make necessary a greater degree of supervision over these cases at home than is now feasible.

From a study of infantile diarrhœa which Dr. Kirly made in the tenement district of New York, he derived a death rate of 2 per cent. for this disease. In the Lower East Side District there were 720 deaths from diarrhœal diseases among children under 5 years of age, of which 685 were in the homes and 35 in institutions. This would mean that there were about 34,250 cases in the homes, or 88 per cent. of all, and 4,750, or 12 per cent., in institutions; a total of 39,000. With an average duration of 8 to 10 days, it was estimated that there were from 274,000 to 342,500 days of sickness at home from this one infants' disease.

Educative work regarding diseases of children has done much within the past ten years to decrease the infant death rate. Certainly it is reasonable to suppose that with additional preventive measures and actual treatment of the sick children at home the number of deaths could be reduced to as absolute a minimum as is humanly possible and the degree of sickness, in a large percentage of cases, greatly decreased in intensity.

Pulmonary tuberculosis caused the deaths of 751 persons in this section

during 1910, of which 33 were in institutions and 718 at home. A study of tuberculosis in this section showed a death rate of 18.6 per cent.—that is, 18.6 per cent. of all those who have tuberculosis die in the course of a year. These 718 deaths at home, then, indicated that there were about 3,900 cases of tuberculosis in the Lower East Side District homes. More will be said of this disease upon another page.

Besides these deaths from cases of principal diseases, there were 3,680 deaths from other causes in the homes in this section. These included diseases of the digestive, respiratory, circulatory, genito-urinary, and nervous systems, skin diseases and all others. It was, of course, impossible to estimate with any degree of accuracy the number of cases of sickness that these 3,185 deaths represented, since almost none of these diseases follow any well defined course, and each case has a distinct history of its own. However, we may assume that a very large number of cases—certainly over 75,000—with a great many days of sickness—from 1,000,000 to 1,125,000—occurred in this section to cause the more than 3,000 deaths from miscellaneous diseases.

West Side District

The total of 47,885 cases of sickness in this section during 1910, representing a rate of incidence of more than 1 out of 3—371 per 1,000 of population—is very much larger than that of the Lower East Side District. The relative amount of sickness at home and in the hospitals also varies from that of the East Side District. Only 2,569 of these West Side cases, or 5.4 per cent. of the total, were treated in hospitals, remaining there for a total of 116,711 days. The cases at home caused a total of 1,427,265 days of sickness.

TABLE II.

SICKNESS IN A WEST SIDE DISTRICT IN 1910.

Diseases.	Actual Number of Deaths in Institutions.	Actual Number of Deaths in the Homes.	Estimated Number of Cases in Institutions.	Estimated Number of Cases in the Homes.	Estimated Number of Days of Sickness in the Homes.	Estimated Number of Days of Sickness in Institutions.	Estimated Number of Cases in the Homes and Institutions.	Estimated Number of Cases in the Homes and Institutions in 1911.
Typhoid Fever	10	10	108	108	5,400	3,240	216	216
Scarlet Fever	6	25	94	391	18,768	3,390	485	300
Diphtheria	8	51	89	567	17,010	2,136	656	490
Pneumonia	19	150	93	735	26,082	1,820	828	870
Broncho-pneumonia	9	175	37	714			751	650
Measles	1	12	67	800	20,000	1,340	867	1,000
Whooping-cough	4	11	133	367	12,845	3,325	500	700
Diarrhœal Diseases	0	187	0	9,350	93,500	0	9,350	6,350
Pulmonary Tuberculosis	14	369	688*	1,984	476,160	82,560	2,672	2,080
Other Diseases	101	1,487	11,260	30,300	757,500	18,900	41,560	18,330
Total	172	2,477	12,569	45,316	1,427,265	116,711	57,885	30,976

1 of every 3 of the population was sick.
78.3 per cent. of all cases of sickness were cared for at home and 21.7 per cent. were in institutions.
* Cases of tuberculosis in institutions from this district were estimated as in Table I.

There were 20 deaths from typhoid fever in 1910, of which 10 were at home and 10 in institutions. There were, therefore, 108 cases in the

homes and 108 cases in institutions, a total of 216 cases, with about 5,400 days of sickness at home. On the charts of the Health Department only 158 cases were reported from this section, leaving about 27 per cent. of the cases not reported.

Scarlet fever caused 31 deaths; 6 in institutions and 25 at home. This would mean about 485 cases of sickness from this disease; 94, or 19 per cent. of all, in institutions and 391, or 81 per cent., at home. These 391 cases estimated to have been at home caused about 19,000 days of sickness. This is a conservative estimate, since, undoubtedly, in a great majority of the cases, the course of the disease was abnormally prolonged by the lack of proper attention or unhygienic conditions. On the other hand, there were probably many cases permitted to be about before the disease had ended.

During the year diphtheria caused 59 deaths in this section; 8 in institutions and 51 at home, which would mean that there were about 90 cases of diphtheria, or 13 per cent. of all, in hospitals and 570, or 87 per cent., at home, and that the latter caused more than 17,000 days of sickness.

There were 353 deaths from pneumonia and broncho-pneumonia. Of these, 19 died of pneumonia in institutions and 9 of broncho-pneumonia, leaving 150 deaths from pneumonia and 175 from broncho-pneumonia at home, which would mean 735 cases of pneumonia, or 89 per cent. of all, and 714 cases of broncho-pneumonia, or 95 per cent., in the homes. This estimated number of 1,449 cases resulted in over 26,000 days of sickness. Over 6.5 per cent. of the total number of deaths from these diseases in Manhattan occurred in this district.

The deaths of children under 5 years of age were 25.1 per cent. of the total number of deaths. This percentage is considerably lower than the percentage of such deaths for the entire City, which is 31.6 per cent. The same decrease also appears in the estimated cases of children's diseases. There were 13 deaths from measles; 12 at home and 1 in a hospital, which would mean about 70 cases, or 7 per cent. of all, in institutions and 800 cases, or 93 per cent., at home, which, it was estimated, resulted in about 20,000 days of sickness. Whooping-cough caused 4 deaths in institutions and 11 at home, which would mean about 140 cases in institutions and 360 at home. These latter, it was estimated, were sick for a total period of about 13,000 days.

According to the estimate, no diarrhœal cases were taken from this section to institutions during the year, but 187 died at home; there were, therefore, about 9,400 cases of the disease at home, with a total of over 94,000 days of sickness.

The death rate for tuberculosis in this district is somewhat higher than in the Lower East Side District—19.1 per cent., as compared with 18.6 per cent. At this rate, the 369 deaths at home and 14 in institutions would mean that there were about 2,000 cases at home, which, it is estimated, caused over 476,000 days of sickness.

The remaining 1,487 deaths at home caused by other diseases would mean that there were 25,000 cases of sickness, with probably more than 500,000 days of illness.

Comparisons of West Side and Lower East Side Districts

The population of the West Side District was 20.8 per cent. of the other; that is, the Lower East Side District contained nearly 5 times as many people, with about 3 times the density of population. The total

number of cases of sickness in the West Side District was 33 per cent. of the other, and, therefore, in proportion to the population, there was more than one and one-half times as much sickness on the West Side. The larger percentage of sickness was in the homes—94.6 per cent. in the West Side District and 89.4 in the Lower East Side District. It was also found that there were proportionately twice as many days of sickness at home in the West Side District as in the other section.

There was 45 per cent. as much typhoid fever in the West Side District as in the Lower East Side District—more than twice as much, proportionately. Of the other principal diseases there were, in proportion to the population, about an equal number of cases of scarlet fever, diphtheria, and broncho-pneumonia. Pneumonia was somewhat more prevalent in the West Side District, there having been 27 per cent. as many cases with only 20 per cent. as much population. The greatest contrast was in the cases of tuberculosis, of which there were, proportionately, 3 times as many in the West Side District as there were in the other section.

The proportion of deaths of children under 5 years of age to the total number of deaths, which was 25 per cent. in the West Side District, was considerably lower than the 43 per cent. in the East Side District, but this does not necessarily mean a lower death rate for children in the former. It represents chiefly a difference in the actual number of small children in the two sections. As will be observed in the account of the results of the house-to-house investigation, a large proportion of the population of the West Side District consists of unattached men and women—boarders, lodgers, etc.—and to this fact is principally due the smaller proportion of children's deaths. This is borne out by the fact that the percentage of deaths from diarrhœal diseases and whooping-cough, these being diseases principally of childhood, was by no means lower in the West Side District, there having been 23 per cent. as many as in the East Side District from diarrhœal diseases and 38 per cent. from whooping-cough, with only 20 per cent. as much population. The percentage of measles cases in the West Side District was somewhat lower, only 16 per cent., while the number of cases of other diseases in this section was 38 per cent. of the total for the East Side District, which was almost twice as much, proportionately.

The chief value of this comparison lies in the fact that it shows clearly the necessity of considering the different sections of the City separately. The sections here studied were selected as being similar in character, so far as type of population and condition of homes were concerned, and the difference in amount and kind of sickness present in the two districts indicates plainly that in planning remedial or supervisory measures the necessities of each particular section should be clearly in mind. Pulmonary tuberculosis appears to be 3 times as prevalent in the West Side as in the East Side District. There were 63 per cent. as many cases in the West Side District with only 20 per cent. as much population; yet the East Side District has three tuberculosis clinics to supply its needs, while the West Side District has only one. Similar differences, with corresponding lack of provision, are present in connection with other diseases. It is plainly evident that individual needs must be studied and provision made for them. This need for individual attention appears more clearly in the results of the house-to-house canvass.

Results of Personal Investigation in the Homes

Lower East Side District

A representative portion of the East Side District was selected; within the area bounded by Stanton Street on the north, Broome on the south, Allen on the east, and Chrystie on the west (the exact location of the section investigated is shown in Diagram 1 accompanying Table III), and investigators visited every family for the purpose of learning the conditions relating to illness in the section during the year 1912.

The questions asked covered the following points: Sickness in the home without professional attendance; visits of private physician; visits to public clinics; cases taken to hospitals; visits of Health Department officials to the home for quarantine or fumigation; etc. In addition to these, social facts were also collected; such as age and sex of patient; condition of dwelling place; number in family; and number of rooms occupied by family. Six hundred and sixty-two families, with an average of 5 in each family—in exact figures, 3,375 people—were visited. Of these, 600 had been sick during the year; an average of about 1 out of 6, or 178 per 1,000 of population. The number removed to hospitals was 59, or 9.6 per cent. of the total, and 541, or 91.4 per cent., were sick at home.

A comparison of the streets investigated shows a marked contrast in the number of cases. On Delancey Street 42 of 262 people, or 160.3 per 1,000 of population were sick; on Eldridge Street 98 of 516, or 189.9 per 1,000; on Rivington Street 80 of 595, or 151.2 per 1,000; on Forsyth Street 240 of 1,418, or 169.2 per 1,000; on Broome Street 81 of 584, or 138.6 per 1,000. The average length of the periods of illness also varied; 68 days on Delancey Street; 91 days on Eldridge Street; 122 days on Rivington Street; 80 days on Forsyth Street; and 52 days on Broome Street.

It is interesting in relation to these facts to consider the character of the homes on these streets. The home conditions on Eldridge and Rivington streets were of the worst description. Congestion and filth were present more prominently in the tenements on these two streets than anywhere else in the section. Inner dark rooms, some with absolutely no means of ventilation except the door, and others with small windows opening on closed shafts, were found in the buildings of this character. Forsyth street was of the same general character of half of the section investigated; namely, the block between Delancey and Rivington streets, where most of the houses have but one sink and toilet on each floor, used in common by all the families. The other half, between Rivington and Stanton streets, contained houses in much better sanitary condition. There was less congestion on Delancey Street—an average of only 1.3 persons to a room—with correspondingly more favorable living conditions. The best houses were on Broome Street. Here the entire block contains tenements of new style, built since the construction of the Williamsburgh Bridge. The rooms are well lighted and ventilated, and each family apartment has its individual toilet and sink—features lacking on the other streets. The decreased average number of days of sickness may not be a direct consequence of better living conditions, but the striking coincidence throughout this street is at least worth noting.

There were 125 confinements during the year in these two blocks, which, for the population of 3,375, made a birth rate of 38.5 per 1,000. The birth rate for the entire City was 26.2. Of these 125 births, 116 were in the homes, and 38 of the latter, or 33 per cent., were attended by midwives,

the mothers in these cases being Italians; 74, or 63 per cent., were attended by physicians, the mothers being Jewish; and in the other 4 cases both midwife and doctor were in attendance. The average number of days of confinement was 9, with a total of 1,020 days. In 9 cases, 7.2 per cent. of all, delivery took place in hospitals; the total number of days for these was 105, making an average of 12 days.

The average of 9 days of confinement in the cases at home include all the time of the midwives' or doctors' visits. As a matter of fact, most of these women were up and doing the household work after only 2 or 3 days in bed. Many of them returned to outside work in 5 days or a week. This condition, coupled with the fact that 33 per cent. of the cases (in the Italian section this percentage would be much larger) are attended by midwives, who are, necessarily, less able to prescribe recuperative remedies than a physician, would seem to account for the prevalence of women's diseases in this section. There were 33 cases of women's diseases at home with an average period of 217 days sickness, and 7 in hospitals with an average of 21 days. None of these cases were of specific infection, being chiefly displacement of organs or general disability. If the connection here suggested is true, it would seem that 32 per cent. of the women confined are later incapacitated by resulting diseases for extremely long periods.

The 57 cases of stomach disorders during the year resulted in a total of 7,703 days of sickness, an average of 135 days for each case. Only 2 cases, or about 4 per cent. of the whole, were removed to hospitals, where they remained for a total of 70 days. Under this heading are included all cases of diarrhœal diseases, constipation, etc., as it was impossible in gathering the data to keep the distinctions clear. Appendicitis occurred in 6 cases, of which 4 were treated in hospitals, where they remained for a total of 130 days, an average of 33 days for each case. The 2 cases at home were ill for a total of 49 days.

Diseases of the respiratory system were the most prevalent of all the ailments in this section. There were 142 cases, or 43 per 1,000 of population, with a total incapacitation of 4,007 days. Keeping in mind the general house conditions on the streets studied and described in a previous paragraph, it is interesting to classify these diseases under their names with the rate of incidence on each street as follows:

Grippe occurred in 78 cases, with a total of 923 days of sickness. Of these, there were 4 cases, or 15.2 per 1,000 of population, on Delancey Street, with an average of 8 days of sickness; 12, or 23.3 per 1,000, on Eldridge Street, with an average of 8 days; 8, or 13.4 per 1,000, on Rivington Street, with an average of 20 days; 45, or 31.8 per 1,000, on Forsyth Street, with an average of 13 days. There were 10 cases of pneumonia, with a total of 310 days of sickness. Of these there were no cases on Delancey Street; 1 case was on Eldridge Street, with 9 days of sickness; 2 on Rivington Street, with an average of 14 days; 4 on Forsyth Street, with an average of 22 days; and 3 on Broome Street, with an average of 62 days. There were 11 cases of bronchitis, with a total of 536 days of sickness. Of these, there were no cases on Delancey Street; 2 cases on Eldridge Street, with an average of 44 days sickness; no cases on Rivington Street; 7 cases on Forsyth Street, with an average of 60 days; and 2 cases on Broome Street, with an average of 14 days. Inflammations and other affections of the throat occurred in 43 cases, with an average of 52 days of sickness in each case. Of these, 4 were on Delancey Street, 5 on Eldridge Street, 10 on Rivington Street, 13 on Forsyth Street, and 11 on Broome Street.

Rheumatism was present in this section in a large number of cases, at the rate of 10.9 per 1,000 of population. There was 1 case on Delancey Street, with 21 days of sickness; 6 on Eldridge Street, with an average of 191 days; 6 on Rivington Street, with an average of 363 days; 20 on Forsyth Street, with an average of 239 days; and 4 on Broome Street, with an average of 279 days.

There were 9 cases of diphtheria, at the rate of 2.7 per 1,000 of population, which approximated the condition throughout the City; the rate of incidence for this disease for the entire City during 1912 being 2.6 per 1,000. Of these 9 cases, 7 were in the homes and 2 were taken to the hospital. There were 19 cases of measles, or 5.6 per 1,000; a rate somewhat lower than that for the entire City, which was 7.5. Of these 19 cases, 17 were sick at home, for an average of 29 days, and 2 were removed to the hospital, for an average stay of 35 days. Scarlet fever was more prevalent in this section than the other infectious diseases, the 23 cases, or 6.2 per 1,000, representing almost three times as great a rate of incidence as that for the entire City, which was 2.4 per 1,000. Of the 23 cases, 18 were in the homes, for an average of 44 days, and 5 were removed to hospitals, for an average of 42 days. Whooping-cough, which is estimated by the United States Public Health Service as having a rate of incidence of about 100 per 100,000, occurred in this section in 9 cases, all at home, at the rate of 270 per 100,000. There were 19 cases of tuberculosis, 17 at home and 2 in hospitals; but it is probable that this does not represent the total number, as there was considerable reticence in acknowledging the presence of this disease in the family. Two cases of spinal meningitis, or 0.6 per 1,000, occurred in this section during 1912.

Diseased conditions of the eye, all of which had been treated at home, were found in 17 cases, or 5 per 1,000 of population, with an average of 107 days sickness: affections of the ear in 10 cases, or 3 per 1,000; of which 8 were sick at home, for an average of 149 days in each case, and 2 in hospitals, for an average of 11 days: heart disease in 9 cases, or 2.7 per 1,000; of which 8 were sick at home, with an average of 183 days, and 1 in a hospital, for 21 days: disorders of the blood in 9 cases, or 2.7 per 1,000; all of which were treated at home, with an average of 15 days: skin diseases in 9 cases, or 2.7 per 1,000, with an average of 69 days sickness: fractures in 9 cases, or 2.7 per 1,000; of which 7 were treated at home, with an average of 75 days, and 2 in hospitals, for an average of 25 days: scattering cases of epilepsy, erysipelas, typhoid, diabetes, etc., of which 30 were sick at home, for a total of 292 days, and 23 in hospitals, for a total of 527 days.

Unsanitary conditions in the home exercise a depressing effect upon the sick person, which is increased in many cases by the poverty and ignorance of the people. Unable to employ a private doctor and unwilling to go to the hospital, large numbers of the sick attempt to find relief at the dispensaries. Many families have the nominal services of their lodge physician, but the people do not seem to place much confidence in these doctors and seldom call them. Where the disease is of a serious nature they call in a private doctor if they can afford it, or visit a dispensary, but in most cases they resort to home treatment, which usually is of the crudest sort.

Entire neglect of the sick often results from various causes. At 297 Broome Street a woman 65 years old was confined to her bed by chronic rheumatism, with no one to attend to her because all the other members of the family were at work. In the same house a woman 80 years old had been in bed 2 years because of general debility, with no one to attend to

her during the day. At 171 Eldridge Street and 156 Forsyth Street, chronic cases of bronchitis and rheumatism were without treatment. At 179 Eldridge Street, a husband and wife afflicted with chronic heart trouble for over a year and unable to move about had been without treatment of any sort. In the next house, No. 177, two children, 2 and 9 years old, respectively, were covered with open sores of some eruptive disease. Nothing had ever been done for them because the mother was "afraid of dispensaries." Many cases, whose external characteristics plainly indicated tuberculosis, had never had the attention of any medical person, and were being treated with home remedies or neglected entirely. There were more than 50 persons ill from fevers, infections, etc., requiring medical aid and not receiving any.

A public dispensary in such a community is of very great importance. The people are willing to go to a dispensary with their ailments provided good treatment is afforded. Of the 600 cases of sickness found in the section, 194, or 32.3 per cent., had visited dispensaries, whereas only 9.8 per cent. of the cases received treatment in hospitals. But of these dispensary cases, 56, or 29 per cent., went only once because the unbearable conditions discouraged them from another attempt; and of the others, 80, or 40 per cent., had been unable to obtain any relief upon repeated visits. The chief complaints made by the people of this section were that the dispensaries are so overcrowded that patients must wait for hours, and that the examinations they receive are superficial and seldom give relief. In some of the dispensaries many patients, sometimes as high as fifteen or twenty, are crowded into one small room, and the physician hurries from one to the other dispensing prescriptions. At the apothecary's window the patients very often wait two or three hours before the prescriptions are filled. One experience of this kind usually serves to prevent the return of the timid ones, or of those who are unable to spend half a day on a dispensary visit.

That the dispensaries are inefficient is the common belief among almost all of the people in this section. Actual cases are furnished to support this opinion. One woman, at 303 Broome Street, whose child was suffering from burns, said that the dispensary treatment was so careless that blood-poisoning developed and she had to pay $50 to a private physician to have the child cured. In a case of eye trouble in a child living at 154 Forsyth Street, the mother was told at a dispensary that "nothing was the matter," but acute inflammation developed later and an operation was performed by a private doctor. Charges are also made that in some of the dispensaries the doctors exploit the patients; ignorant persons are told that the disease cannot be cured at the dispensary and that the patient must come to the doctor's private office, at a certain price per visit.

The efficiency of the public dispensary has been treated more fully in another part of this Report which deals with the condition in one of the dispensaries maintained by the City.

Middle West Side District

The section of this district selected for personal investigation of sickness at home included the block bounded by Seventh and Eighth Avenues, and 35th and 36th Streets; 35th Street between Ninth and Tenth Avenues; and Tenth Avenue between 34th and 35th, and 36th and 37th Streets (the exact location of the section investigated is shown in Diagram II accompanying Table IV). The information sought covered the same points as

the investigation of the East Side District. A total of 464 families, with an average of 4 in each family—1,959 people, to be exact—were visited. Of these, 405 had been sick during the year, an average of about 1 out of 5, or 206 per 1,000 of population. The number removed to hospitals was 50, or 12.3 per cent. of the total cases of sickness; and 355, or 87.7 per cent., were sick at home. The percentage of hospital cases was larger than that for the East Side section, a condition somewhat at variance with the estimates made for the entire districts (Tables I and II). The other estimates, as to the relative total number sick and the relative number of cases of certain diseases, were effectively borne out by the results of the house-to-house canvass.

The house conditions throughout this section are extremely bad. The very worst are on the north side of 35th Street between 7th and 8th Avenues, where the houses are three-story tenements, very dilapidated and filthy, and with rear tenements of the same noisome character. In several of these houses the toilets, used in common by all the families on a floor, were out of order, causing sickening odors throughout the building. Defective plumbing in many cases—this condition, according to the report of the tenants, having been present for several years—had resulted in rotten floors and hallways, with accompanying odors and immediate danger of accidents. The basements occupied in most of the houses by two or four families were uniformly dark, damp, and filthy. In many instances one section of the basement was used as a depository for garbage, with one or two families occupying the adjoining section. It is difficult to depict the squalor found in this section. Personal and moral cleanliness seemed to be very lightly regarded throughout, and disorderly living quite common. In many cases the occupants of the house comprised a male or female head of the "family," with a large number of boarders or lodgers.

There were 58 cases of confinement in this section during the year, making for the population of 1,959 a birth rate of 29.6 per 1,000, which was 8.9 less than the rate in the East Side section. Of the 58 cases, 56, or 97 per cent., were at home, for an average of 9 days each; and 2, or 3 per cent., went to hospitals, for a total of 25 days.

The relatively small number of births may have in some measure affected the number of cases of women's diseases. There were 12 cases of these in the homes, none of them being of specific infection, with an average of 210 days sickness; and 1 in a hospital, for 9 days. The total cases averaged 6.6 per 1,000.

That unsanitary living conditions, together with the consequent debilitated constitutions, are strong predisposing causes for diseases of the respiratory system is a fact so generally accepted as to hardly need repetition. In this block the prominence of such diseases makes it impossible to avoid associating them directly with the exceedingly unfavorable home environment. There were 88 cases of pneumonia, bronchitis, pleurisy, asthma, etc., or 44.4 per 1,000 of population, with an average of 43 days sickness in each case, which was almost twice as much as the rather large average in the East Side District. If pulmonary tuberculosis be included in this classification, as there is good reason for believing it should, the disease rate directly traceable to home conditions amounted to 53.1 per 1,000, with an average sickness of 58 days. Of these, 11 per cent. were taken to hospitals and 89 per cent. were sick at home.

Rheumatism also, as in the East Side section, was highly prevalent in this section, but in still greater proportion; there having been 20.9 cases per

1,000 of population (as compared with the 10.9 per 1,000 in the East Side District), with an average length of 189 days sickness for those cases that were in the homes, or 90.1 per cent. of all, and an average of 61 days for the 9.9 per cent. that were removed to hospitals.

Diseases of the digestive organs occupied a principal position among the ailments in this section. There were 60 cases, which means the remarkably large rate of incidence of 30.7 per 1,000 of population (12.3 greater than in the East Side District), with a total of 4,610 days sickness, with an average of 77 days in each case. Of the 60 cases, 6, or 10 per cent., were in hospitals for a total of 245 days.

Diphtheria occurred in 12 cases, the rate of incidence, 6.1 per 1,000, being more than twice as great as that for the entire City. Measles also had a large incidence in this section, having been 9.2 per 1,000, which was 1.7 more than the entire City rate. The rate for scarlet fever, 2 per 1,000, was slightly less than that for the City. Whooping-cough occurred at the rate of 1 per 1,000, which was equal to the estimate for the entire country. The 16 cases of tuberculosis found, very probably, as in the East Side District, did not represent the true total. There were 6 cases of chickenpox, or 3.1 per 1,000, with an average of 24 days sickness.

Neglect of the sick is a more common occurrence in this section than in the East Side District. A large part of the population consists of unattached men and women lodgers, and families of two or three members, a situation in which it is almost impossible for a patient to receive adequate attention. The idea of going to a hospital occurs to most of these people only as a last resource. Their dislike for hospital treatment is very deep-seated, and is based on current rumors of mistreatment in hospitals and general inefficiency. The antipathy toward the public dispensary is even stronger here than in the East Side District. Only 21 per cent. of those who were sick had ever visited a dispensary, as compared with the 32.3 per cent. in the East Side District, and of these, 15.3 per cent. went only once. They complained of abusive language, lack of examination, and inefficient treatment.

SUGGESTED HEALTH CENTERS

The foregoing estimate and examination of sickness in the home make it reasonably clear that there is a large amount of sickness which could be alleviated or prevented by a reasonable amount of supervision on the part of properly constituted agents. It is, of course, an open question how far the City should go in attempting to prevent and care for disease. Thus far the sole function of the hospital has been to receive and treat the sick. Little attempt has been made to inquire into the contributory causes of sickness, except contagions; nor has sickness been followed from the hospital to the home in an attempt to further relieve, except in a very limited degree. Such work of prevention as is carried on by the City is being performed by the Health Department. This Department, in addition to watching the milk and water supply and controlling contagions, examines school children for contagion, maintains milk depots, a few clinics for tuberculosis, and regulates midwifery.

The City has assumed the responsibility of caring for sickness when it reaches a stage needing hospital treatment and, within certain limits, for the prevention of contagious disease. Any theory of social obligation which warrants the City in undertaking the care and prevention of sickness would warrant its going still further, if its finances would permit. For instance, the City is maintaining a police patrol on the watersheds to prevent pollution; is maintaining laboratories for the examination of drinking water; is providing inspectors to examine the dairies throughout the districts from which milk is shipped to New York City; and closely follows any outbreak of typhoid epidemic. Such cases of typhoid as do appear, if application is made, are received into municipal hospitals and there cared for. The examination of health conditions made by this Committee, however, shows that out of 44 deaths by typhoid in the district examined on the East Side, 16 occurred in institutions and 28 at home. It appears that 65 per cent. of the typhoid sickness was in the homes and 35 per cent. in the hospitals. How these cases of typhoid were cared for, we have no means of knowing. It is probable that in nearly all cases private physicians were in attendance, but how carefully these private physicians guarded conditions in the home to prevent the spreading of this contagion, we do not know. Judging by reports from quite a number of families, typhoid became epidemic in certain households.

The Inspectors of the Department of Health visit homes in connection with certain contagions to make certain that the cases are cared for by private physicians, but seldom more than one or two visits are made. From these brief visits it is impossible to gain a clear knowledge of the conditions that are maintained in the household during such contagion. It was noted by the foregoing examination that in the East Side Section there were about 127 cases of scarlet fever cared for at home, 216 of diphtheria, and 76 cases of measles. Judging by the reports of the field inspectors of this Committee, in a number of cases there was reasonably clear evidence indicating that these contagions had spread to other members of the family or to neighboring families. Aside from those contagions recognized as quarantinable, there were about 730 cases of pneumonia in the homes, 38 cases of

spinal meningitis, and 34 cases of whooping-cough, which diseases are generally recognized as infectious. What precautions were taken against the spreading of the infection is unknown.

From the examination of the results of treatment at Gouverneur Hospital, shown upon previous pages in this Report, it was discovered that about one-third of the persons visiting the Out-Patient Department for the first time did not return for subsequent treatment. The explanation given by many who were interviewed as to the reason for not returning was that they were badly treated at the Out-Patient Department. These people seemed to be under the impression that their cases were too hastily or inadequately diagnosed, or that a lack of sympathy was shown, or for other reasons they were displeased with the handling of their cases. In many instances cited in that part of this Report referred to above, the treatment was evidently inadequate, and required the attention of physicians subsequent to the visit made to the Out-Patient Department. It is a great waste of work to treat cases but once in an out-patient department when a cure can be effected only by continued treatment, and it would seem reasonable that efforts should be made to induce such persons to return to the out-patient department for subsequent treatment.

None of New York City's municipal out-patient departments has nurses who can follow cases to the homes. Such follow-up work has been carried on for several years by the Boston Dispensary and by the Out-Patient Department of the Presbyterian Hospital in this City. The Boston Dispensary reports that the average number of visits of each patient has been increased from 3.1 to 4.54 since the introduction of the follow-up system. The Presbyterian Hospital authorities feel very confident that their system of sending nurses to the homes has resulted in the cure of a great many cases that otherwise would have attended the Out-Patient Department but once, with ensuing unsatisfactory results. The outlay necessary to maintain the follow-up system in connection with both the Boston Dispensary and the Presbyterian Hospital, in the opinion of the governing bodies of these institutions, is justified by the results obtained. Undoubtedly the work of the out-patient departments of the municipal hospitals in New York City likewise would be greatly improved if these departments would follow their cases to the homes.

If the City of New York is justified in spending money for the cure of disease, it would seem the part of economic wisdom to spend money for its prevention. Undoubtedly a larger percentage of disease could be prevented than is now the case if a more thorough system of home visitation existed for the purpose of regulating the sanitary conditions surrounding home treatment, and for the purpose of informing all citizens of means and methods of maintaining sanitary and healthful conditions. How far the City should undertake such a program of work is yet problematical. The methods of doing such work, its cost, and the results to be obtained, cannot be determined without experimentation. The City ought to try an experiment in a small district, and in a limited way, to determine, if possible, whether or not such work could advantageously be performed by the City as a regular part of the work of the Health Department and the hospitals. It should undertake this experiment also to determine whether or not a large portion of sickness can be cared for at home more cheaply than in expensive hospitals.

This work could be undertaken by physicians and nurses from Bellevue, and also physicians, nurses, and inspectors from the Department of Health.

If these representatives of the two Departments were to be associated together in one center it would insure not only the coöperation of the two Departments, but would also make certain that no conditions which would contribute to the health of the community would remain unknown because of a lack of definition of duties which should be performed by the two Departments.

The proposed Health Center is designed as an experiment to enable the City to determine whether or not: (a) it should attempt to give home treatment; (b) cases can be classified as those which should or should not go into hospitals for treatment; (c) information as to living and working conditions will aid in the prevention and treatment of sickness.

A Health Center properly operated should accomplish the following results:

1. It would bring the hospitals and Health Department into coöperation, and leave no uncovered territory between the functions performed by each.
2. It would enable the hospitals to secure thorough knowledge of the working and home conditions of patients coming into the hospitals, and any factors contributing to sickness.
3. It would retain at home many patients that otherwise would go to the hospitals, and would exercise an intelligent opinion as to those that should or should not be treated in the hospitals.
4. It would give more intelligent care to convalescing patients, which is now given in but a limited degree by the Social Service Department of Bellevue Hospital, and would restore these patients to health and working vigor much sooner than is now done.
5. It would advise patients when to go to an out-patient department, and, by visits to their homes, would induce them to make as many subsequent visits as might be needed to effect a cure.
6. By maintaining supervision over contagious and infectious cases cared for at home, their possible spreading would be minimized.
7. Cases of contagion discovered by the physicians and nurses of Bellevue would come to the notice of the Inspectors of the Health Department at once and thus would be obviated the delay due to the process of notification by mail.
8. The instruction of mothers in a Health Center should be a material aid in securing and maintaining health conditions in the family.
9. Centralizing information and records of a district at one place would make them accessible to all agents in the district, thus rendering it possible to treat a large proportion of sickness at its inception. By this system, duplication of effort would be reduced, the hospitals would be relieved, and the amount and duration of sickness diminished.

Work and Organization of the Health Center

It is proposed that the City perform an experiment by establishing and maintaining one Health Center for a sufficient period to determine whether or not the work performed by it would meet a social need, and should or should not be enlarged and extended. The location, character of plant, method of operation, and estimated cost of maintenance may be described as follows:

Location

The Health Center should be located in the Bellevue ambulance district, in order that the portion of its work assigned to the Bellevue Department may be supervised by the officers of Bellevue, and also that the patients having been discharged from Bellevue Hospital and those in attendance at the Bellevue Out-Patient Department and residing within the Bellevue district may be assigned to the physicians and nurses of the Health Center for after-care. The building should be selected by the Health Department, since the major portion of its space would be occupied by the work of this Department.

Functions to be Performed

1. All of the functions now performed by the different bureaus of the Health Department as pertaining to this district should be centralized in this building. The functions as at present performed consist of:

(a) A tuberculosis clinic.
(b) A child hygiene clinic, having associated with it a milk depot.
(c) A dental clinic for children.
(d) Inspectors of contagious and infectious diseases, and visiting nurses associated in that work.
(e) Inspectors and nurses in charge of the inspection of school children for the purpose of detecting infectious or contagious diseases.
(f) The supervision of midwives.

The work now carried on by the different bureaus of the Health Department as outlined above, but at present in separate centers, could be similarly performed when associated together in one Health Center.

2. Bellevue Hospital would assign to this Health Center 1 graduate interne, 2 trained social service nurses, and 4 nurse-attendants. Patients residing in this district, discharged from Bellevue and needing after-care, and patients attending the Out-Patient Department of Bellevue would be referred to these agents of Bellevue, who would visit them in their homes with the object of seeing that they received the proper after-care, or that they carried out the instructions of the physicians of the Out-Patient Department, both in home treatment and by returning at stated intervals to the Out-Patient Department for subsequent treatment. In performing this work many new cases would come to the attention of these physicians and social service nurses, and decisions would be rendered as to whether or not they should receive care on the part of the City, and whether this care should be given at home or in Bellevue Hospital, according to the character of the sickness and the condition of the home.

In the beginning it would not seem advisable to have any of the patients visit the Health Center for treatment, but all treatment should be administered in the homes of the patients. After the Health Center had been operated for some time it might seem to be advisable to have certain classes of the patients come to the Health Center for continuation of treatment initiated at Bellevue. Such treatment might consist of redressing wounds, spraying and cleansing of throat, nose, ears, and eyes, and such other continuation treatment that may be of a simple nature and practical to administer with few appliances.

3. At this Health Center would be located all of the records pertaining to the district in which it is located, and these centralized records, which would contain information both of a medical and social nature, would be

consulted by workers of the Health Center, whether from the Department of Health or from Bellevue. By thus centralizing information, a worker in any bureau, or from other departments or social agencies, would at once know whether or not there had been sickness in the home of the family which they were planning to visit, the nature of such sickness, the character of the home, and such other information as would throw light upon the factors which in the past contributed toward sickness.

Assignment of Cases

After the Health Center has been established for some time, and some of its problems simplified, it may be found advisable and feasible to assign nurses to sub-districts, or, at least, to families, and have them be responsible for all of the sickness in such sub-districts or in connection with such families. At the present time it not infrequently happens that nurses from several different bureaus or from bureaus of the Health Department and from Bellevue visit different members of the same family, thus duplicating work. This duplication of effort could be obviated by the centralization of bureaus and records.

Control of the Plant

Inasmuch as the Health Department would occupy the larger part of the proposed plant and perform most of the functions, it would seem advisable to place the control and operation of the physical plant in charge of the Health Department, and such space, of course, as might be needed for the work of Bellevue Hospital would be set aside for its purpose.

Cost of Operating the Various Functions

All of the functions of the proposed Health Center to be assigned to the Health Department are at present performed by that Department, and the expense of centralizing their execution in such a plant would not materially increase their individual or aggregate expense.

The work to be carried on by Bellevue would require 1 graduate interne, at an estimated salary of $900; 2 trained social service nurses and 4 nurse-attendants, at an estimated expense of $1,200 for nurses and $2,400 for the nurse-attendants.

A large element of value of such a Health Center would be the centralized records, to be consulted by the various workers of both departments. To maintain these records would require 1 copyist, for additional work not now done, at an estimated cost of $720.

A recapitulation of the above estimate is as follows:

1 physician (with maintenance at Bellevue)....	$900.00
2 trained social service nurses (with maintenance at Bellevue)	1,200.00
4 nurse-attendants (no maintenance).....	2,400.00
1 copyist (no maintenance).....	720.00
Proportion of rent to be paid by Bellevue.....	600.00
	$5,820.00

Possible Economies Resulting from its Operation

It is impossible to estimate the saving in dollars and cents to the Departments of Bellevue and Health which would result from the installation and operation of such a Health Center. Undoubtedly it would permit Bellevue to discharge some patients somewhat earlier than at present, although little gain may be expected from this source, inasmuch as the Hospital at the present time is discharging patients much earlier than advisable. Our municipal hospitals as at present operated do not care for a patient until restored to strength and able to work, but only during the acute stage of his sickness. If the City should care for patients until able to work, either their stay in hospitals would be longer than at present, or it would be necessary to care for them in their own homes or in convalescent homes. Such a system of district nursing and attending physicians as provided by the Health Center could care for these patients in their homes, and shorten their period of sickness and absence from work. The City by this system might not directly secure economy in operation, but at least would perform more fully and satisfactorily a function which it has assumed.

A direct saving would be secured by caring for a certain proportion of patients in their homes that otherwise would be sent to the hospitals and there maintained. The number that could thus be cared for at home is entirely problematical, although during 1912 nearly 4,000 of the admissions to Bellevue were readmissions, and it is fair to assume that quite a proportion of such readmissions could have been cared for at home by district nurses. This care of patients at home would not only save the hospitals the cost of maintaining these patients, but also the cost of admitting and discharging them. The cost of maintaining a patient in the Hospital is, including carrying charges, about $2.50 per day, and an average stay is about 12 days, so that each patient cared for at home instead of in the Hospital would be a material saving. The process of admitting a patient to Bellevue Hospital requires the co-operation of at least 19 persons, using in the aggregate about 2 hours and 30 minutes. The process of discharge occupies about 11 persons, and uses in the aggregate about 40 minutes. This time, estimated at the rate of $3 per day, costs Bellevue somewhat over one dollar for the process of admitting and discharging a patient. It is very probable, therefore, that a large portion of sickness could be cared for through the means of Health Centers and home visiting more economically than in our hospitals, which are very expensive to build and to operate.

The Health Center and Local Physicians

It may be argued that the assignment of district physicians to render services free in the homes would, to a certain extent, interfere with the practice of private physicians, and therefore arouse their opposition. This argument may be met by the statement that district physicians employed by a city are not an innovation; that for many years they have been employed by some cities and are recognized as performing a part of the functions of the hospitals. Complaint has been made in some cities where district physicians are employed that they take advantage of their position and charge poor people fees, when they are supposed to render their services gratuitously. This charge is undoubtedly well founded in certain instances, but this complaint is possibly largely due to the fact that the physician is allowed to carry on private practice and also to express the opinion as to whether or not a family is able to pay. Under the system proposed for New York the physicians would not practice, and the opinion as to the financial condition of the family would be expressed by the visiting social service nurse, who

would inquire into the circumstances of the family. This would eliminate, in a large degree, the objections found in other cities. Under these circumstances, private physicians would have little ground for legitimate complaint.

General Statement

In considering the foregoing proposed Health Center it should be borne in mind that nearly 90 per cent. of sickness takes place in the homes rather than in hospitals. Sickness in families of the middle and upper classes is adequately cared for by private physicians, but sickness in the homes of the working class and the poor is inadequately cared for, owing to the lack of funds with which to secure medical attendance or nursing help. It follows then that but two classes are well cared for when sick; namely, the well-to-do, who can afford the best of nursing at home, and such of the poor as go to hospitals. However, the amount of sickness cared for by these two methods is a small proportion of the total sickness in the community.

In the early history of our country, when communities were small, there were neighborhood mothers who rendered, for love of the service, nursing service to any who were sick and in need of their help. In the development from small communities to large cities, the neighborhood mother has ceased to render nursing service, and no one has taken her place, except the trained nurse, who must receive more for her services than the laboring man or a poor person can afford to pay. As a result of the development of the large cities and the concurrent loss of the neighborhood mothers a great proportion of the population is without adequate care in time of sickness.

The hospital can never be an adequate substitute for the home, for the largest proportion of sickness has been and will continue to be cared for in the latter. If a municipality assumes the obligation to adequately care for sickness and to prevent it when possible, measures must be taken to render service in the home. It is idle to argue that, if a city provides hospitals, the people, when sick, should go to those hospitals. There are many circumstances under which a sick member of a family cannot leave home. A widow with several children cannot leave her children uncared for while she is sent to and remains in a hospital. Her anxious care for their welfare would militate against recovery were she in a hospital; while, on the other hand, should she be nursed in her home, with her children about her and well cared for, the relief from anxiety would lessen the strain of sickness and hasten recovery.

At the present time a municipal hospital is unable to select the patients that should and do come to its door. Not infrequently those most in need of the care and attention that a hospital can give remain at home, and those who could be well cared for at home go to the hospitals. This condition cannot be corrected so long as hospitals do not extend their work beyond their own doors. If the City is to care for patients at great cost it should have some means of knowing whether or not it is caring for the cases that are most in need of its help. At the present time the City has no such knowledge nor means of securing it.

The City is proposing to expend fully $10,000,000 in a new Bellevue Hospital. This will be one of the best equipped hospitals in the world. How are its facilities to be used to accomplish the best results? Who are to occupy its beds? Will the aggregate amount of sickness be diminished because Bellevue exists? It would seem to be the part of wisdom for the City to inquire whether or not it could care for more sickness for less money by caring for a portion of it in the homes, and by reserving its expensive hospitals for the care and treatment of those cases only which need special equipment and attention that cannot be supplied in the homes.

TABLE III.

Sickness in an East Side District.

The Results of a House-to-House Investigation in the Homes in Certain Blocks Described in the Report are Shown Below.

Cases of Sickness at home.

Nature of Sickness.	Delancey Street.				Eldridge Street.				Rivington Street.				Forsyth Street.				Broome Street.				Grand Total.			
	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.
Liver Diseases									1	365	365	1.7	2	455	228	1.4	4	439	110	6.8	7	1,259	180	2.1
Rheumatism	1	21	21	3.3	6	1,148	191	11.6	6	2,175	363	10.1	20	4,785	239	14.1	4	1,116	279	6.8	37	9,245	249	10.9
Childbirth	11	82	7	41.9	22	229	11	42.6	13	126	10	21.8	53	442	8	37.3	17	141	8	29.1	116	1,020	9	34.3
Appendicitis	1	14	14	3.8									1	35	35	0.7					2	49	25	0.6
Measles	3	141	47	11.4	4	71	18	7.7	3	67	23	5.0	4	167	42	2.8	3	49	16	5.1	17	495	29	5.0
Scarlet Fever	6	350	58	22.9	3	49	16	5.8	3	200	67	5.0	2	63	32	1.4	4	126	32	6.8	18	788	44	5.3
Diphtheria	1	35	35	3.8	5	46	9	9.6					1	3	3	0.7					7	84	12	2.1
Stomach Troubles	4	771	193	15.2	8	966	121	15.5	8	1,567	195	13.4	28	3,656	131	19.6	9	743	62	15.3	57	7,703	135	16.9
Women's Diseases	2	570	285	7.6	5	1,565	313	9.6	8	2,207	275	13.4	15	2,386	158	10.6	3	432	144	5.1	33	7,166	217	9.4
Whooping-cough	1	35	35	3.8	1	180	180	1.9	4	348	87	6.7	3	355	118	2.1					9	918	102	2.7
Pneumonia					1	9	9	1.9	2	28	14	3.4	4	86	22	2.8	3	187	62	5.1	10	310	31	3.0
Tuberculosis					7	2,555	365	13.5	5	864	173	8.7	3	1,090	363	2.1	2	98	49	3.4	17	4,607	271	5.0
Throat Affections	4	743	186	15.2	5	58	12	9.6	10	739	74	16.8	13	616	47	9.1	11	82	7	18.8	43	2,238	52	12.8
Eye Diseases					5	363	73	9.6	2	63	33	3.4	8	1,291	161	5.6	2	100	50	3.4	17	1,817	107	5.0
Fractures					3	97	32	5.8	1	300	300	1.7	3	118	39	2.1					7	515	75	2.1
Grippe	4	31	8	15.2	12	95	8	23.3	8	159	20	13.4	45	578	13	31.8	9	60	7	15.3	78	923	12	23.1
Ear Diseases	2	50	25	7.6	2	545	273	3.9					3	389	129	2.1	1	210	210	1.7	8	1,194	149	2.4
Blood Disorders	2	28	14	7.6	3	34	11	5.8					4	76	19	2.8					9	138	15	2.7
Heart Trouble					1	365	365	1.9	1	365	365	1.7	6	735	123	4.2					8	1,465	183	2.4
Skin Diseases					2	48	24	3.9					7	576	82	4.9					9	624	69	2.7
Tapeworm																								
Teething									3	92	31	5.0									3	92	31	0.9
Bronchitis					2	88	44	3.9					7	420	60	4.9	2	28	14	3.4	11	536	49	3.3
Nervous Disorders					1	365	365	1.9					3	385	128	2.1					4	750	188	1.2
Tonsillitis									1	30	30	1.7	2	9	5	1.4					3	39	13	0.9
Ringworm													1	7	7	0.7					1	7	7	0.3
Spinal Meningitis																	2	152	76	3.4	2	152	76	0.6
Epilepsy																	1	90	90	1.7	1	90	90	0.3
Typhoid																	1	21	21	1.7	1	21	21	0.3
Erysipelas																	1	90	90	1.7	1	90	90	0.3
Mumps					1	5	5	1.9													1	5	5	0.3
Hemorrhages					1	35	35	1.9													1	35	35	0.3
Infantile Paralysis													1	365	365	0.7					1	365	365	0.3
Miscellaneous (caused by accidents)									1	49	49	1.7	1	2	2	0.7	2	67	34	3.4	4	118	29	1.2
Totals	42	2,871	68	159.3	100	8,916	89	193.1	80	9,744	122	151.2	240	19,090	80	166.7	81	4,231	52	138.0	543	44,858	83	160.7

Cases of Sickness in Hospitals.

Nature of Sickness.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.
Measles	2	70	35
Diabetes	1	14	14
Childbirth	9	105	12
Tumor	2	24	12
Women's Diseases	7	147	21
Stomach Troubles	2	70	35
Kidney Diseases	2	70	35
Fractures	2	49	25
Appendicitis	4	130	33
Tuberculosis	2	102	51
Catarrh	2	37	19
Abscess	2	79	40
Ear Diseases	2	22	11
Fistula	2	74	37
Tonsillitis	3	12	4
Rheumatism	1	60	60
Diphtheria	2	47	24
Scarlet Fever	5	211	42
Pneumonia	1	14	14
Heart Trouble	1	21	21
Hemorrhage	1	12	12
St. Vitus' Dance	1	7	7
Breast Infection	1	30	30
Rupture	1	30	30
Adenoids	1	1	1
Totals	59	1,438	26

Total population	3,375
Percentage of total population sick	17.8
Percentage of total population sick in homes	16.0
Percentage of total population sick in hospitals	1.8
Percentage of sickness in homes	90.2
Percentage of sickness in hospitals	9.8

DIAGRAM I.

LOCATION OF HOUSE-TO-HOUSE INVESTIGATION IN A LOWER EAST SIDE DISTRICT.

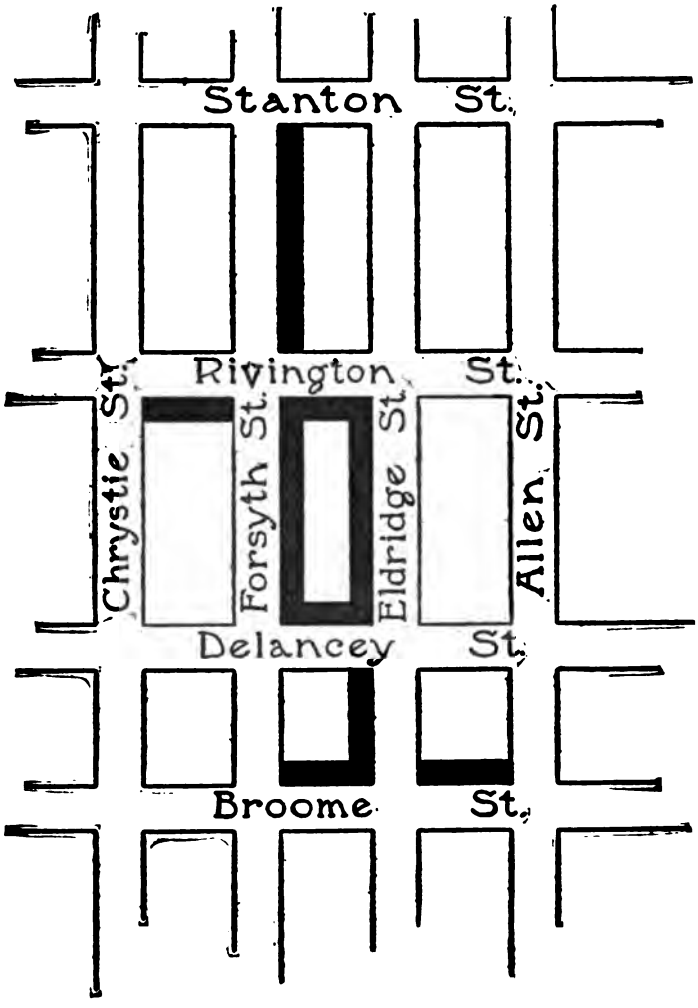


TABLE IV.

Sickness in a West Side District.

The Results of a House-to-House Investigation in the Homes in Certain Blocks Described in the Report are Shown Below.

Cases of Sickness at Home.

Nature of Sickness.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.	Number of Cases per 1,000 Population.
Kidney Diseases	10	1,793	179	5.1
Childbirth	56	478	9	28.5
Rheumatism	37	6,984	189	18.8
Measles	18	176	10	9.2
Appendicitis	3	7	2	1.5
Scarlet Fever	4	128	32	2.0
Diphtheria	10	241	24	5.1
Stomach Troubles	41	2,565	63	20.9
Whooping-cough	2	77	39	1.0
Women's Diseases	12	2,525	210	6.0
Pneumonia	17	478	28	8.6
Tuberculosis	12	1,926	161	6.0
Eye Diseases	5	1,126	225	2.5
Throat Affections	12	198	16	6.0
Grippe	36	254	7	18.3
Fractures	1	49	49	0.5
Skin Diseases	4	234	59	2.0
Asthma	5	1,825	365	2.5
Miscarriage	3	24	8	1.5
Milk Infection	1	63	63	0.5
Cancer	3	679	226	1.5
Bronchitis	8	561	70	4.0
Hemorrhages	3	249	83	1.5
Heart Trouble	10	1,134	113	5.1
Tonsillitis	6	87	15	3.0
Senility	2	730	365	1.0
Chickenpox	6	143	24	3.0
Dropsy	1	90	90	0.5
Pleurisy	2	132	66	1.0
Goitre	1	365	365	0.5
Blood Disorders	1	7	7	0.5
Lumbago	1	365	365	0.5
Meningitis	1	7	7	0.5
Miscellaneous (caused by accidents)	21	347	17	10.7
	355	26,047	73	181.2

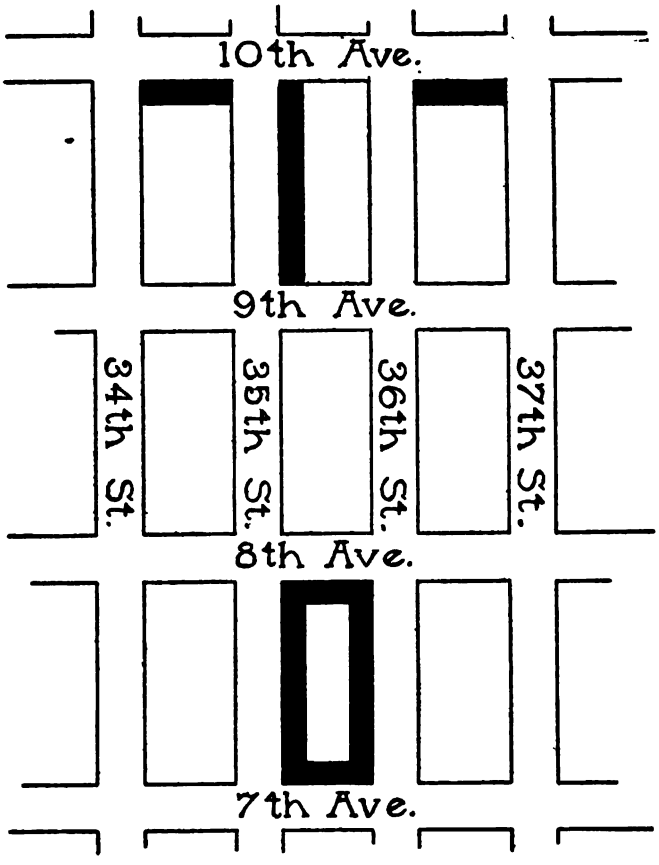
Cases of Sickness in Hospitals.

Nature of Sickness.	Number of Cases.	Total Number of Days Sick.	Average Number of Days Sick.
Diabetes	1	180	180
Childbirth	2	25	13
Tumor	5	184	37
Women's Diseases	1	9	9
Fractures	2	127	64
Appendicitis	5	65	13
Tuberculosis	4	411	103
Catarrh	2	28	14
Abscess	1	42	42
Tonsillitis	3	23	8
Rheumatism	4	242	61
Diphtheria	2	12	6
Rupture	1	21	21
Pneumonia	6	179	30
Spinal Meningitis	2	35	18
Piles	1	21	21
Cancer	4	24	6
Hemorrhage	1	14	14
Miscellaneous (caused by accidents)	3	23	8
	50	1,665	33

Total population	1,959
Percentage of total population sick	20.6
Percentage of total population sick in homes	18.1
Percentage of total population sick in hospitals	2.5
Percentage of sickness in homes	85.9
Percentage of sickness in hospitals	14.1

DIAGRAM II.

LOCATION OF HOUSE-TO-HOUSE INVESTIGATION IN A WEST SIDE DISTRICT.



Section VIII.—HOSPITAL EMPLOYEES

1. Hospital Helpers
2. Proposed Salary and Wage Schedule for the Department of Public Charities

1. HOSPITAL HELPERS

THE INVESTIGATION

The Problem

The menial work, some portion of the clerical work, and a portion of the attendant service in the wards in the municipal hospitals in New York City are performed by persons officially classified as Hospital Helpers. They are, especially in the lower grades, chiefly recruited from the ranks of the "down and outs" and the "periodic drunks." The pay of these Hospital Helpers ranges from $60 to $720 per year. Between and including these minimum and maximum rates are 21 grades. It has been the general custom of the Board of Estimate and Apportionment to appropriate the amount required for these Helpers in blanket amounts for the respective departments. In the Budget for 1912, for the Department of Bellevue and Allied Hospitals, a specific amount was appropriated in each grade for a specified number of Helpers. For the Department of Charities, a blanket amount was provided. It has been repeatedly stated by Commissioners of Charities and by the superintendents of municipal institutions that this class of help has been, and is, very unreliable, resulting in frequent changes in personnel. In the 1909 Annual Report of the Department of Public Charities, Commissioner Robert W. Hebberd made the following statement in regard to Hospital Helpers:

> The principal general needs of the Department, briefly stated, are, a better class of Helpers in the lower grades, and a more rapid extension of the facilities for the care of patients and inmates of the institutions.
>
> Better Helpers can only be secured through an increase in the budget allowance for the wages of such Helpers, as well as the exercise of greater care in their selection, which would then be practicable.

The Commissioners of the State Board of Charities representing New York City, in a report dated July 10, 1911, on the "Department of Public Charities of the City of New York," made the following statement with regard to the employees of the municipal hospitals:

> The problem of getting and keeping competent employees is apparently as far as ever from solution, while the actual situation is more trying than ever. The necessary nurses for the new neurological hospital at the City Home, Blackwell's Island, were secured only by sacrificing by transfer the salary designed for the Deputy Medical Superintendent at the Randall's Island institution. Such makeshifts are often necessary to provide sufficient help to keep the work of the Department going. Perhaps more serious is the matter of the low wages allowed to employees in the lower grades. It is officially announced (October, 1910) that, of 2,361 employees, 1,208 are paid at the rate of less than $240 per year. Of these, 1,050 are rated at $150 or less per year. In this part of the working force there are above 6,000 changes during each year, an average of about 5 in each of the positions involved. That the work of the institutions is accomplished at all with such an underpaid and unstable corps of workers is remarkable; that persons entrusted with duties having to do with the care of the aged, the sick, and the helpless are expected to work for such wages is a disgrace to the City.

It has been, and is, the opinion of officers of the institutions that if the pay of this class of employees were raised more reliable help could, and

would, be secured, resulting in a less frequent change in personnel and more reliable service. Repeated recommendations to this end have been made to the Board of Estimate and Apportionment, and from time to time additional funds have been appropriated, resulting in a somewhat increased pay from year to year. The minimum pay in Bellevue at present is $180 per year. In 1908, City Hospital, Metropolitan Hospital, New York City Home (Blackwell's Island), and Kings County Hospital combined had an average of 37 employees receiving less than $120 per year. In 1911 but one of these four institutions, namely, City Home, had retained any employees below the grade of $120, and this institution had 2, 1 at $60, and another at $90. In other words, between 1908 and 1911 the grades below $120 had been dropped and the average pay had been increased.

An endeavor has been made to ascertain what the effect of the gradual increase in the amount of pay has been on the average length of service of these employees, and also to ascertain what the relative length of stay has been in the grades receiving different amounts of pay.

Scope and Method of Inquiry

To secure data which would represent average conditions and tendencies the records of the Departments were consulted covering a period of 4 years, beginning January 1, 1908, and ending December 31, 1911. These records were taken from the Civil List of the *City Record* published semi-annually, January 1 and July 1 of each year, which list gave the name of each employee, his classification, date of entry into the service, date of discharge, and any increase or decrease in salary. All employees having left the service during the 4 years were summarized under the grades in which they served at the time of leaving the service. The number serving in each grade was ascertained by counting those remaining upon the roll at a given date; and these figures were checked with the payrolls of the institutions. The summary taken from the *City Record* did not in all cases correspond with the report made by the institutions. Where the institutions made report their figures were accepted rather than the count taken from the *City Record*. This method of tabulation has made it possible to ascertain the total number employed in each grade as of a given date; the total number having left the service during a given period; the percentage of changes based upon the number in the grade; and a comparison of the percentages of changes in the different grades. By covering a period of 4 years the effect on the length of stay of raising the pay could be more readily noted.

Results

In summarizing the results of the tabulations in the Department of Charities the following institutions have entered into the computations: City Hospital, including training school; Metropolitan Hospital, including training school; City Home, Blackwell's Island; Children's Schools and Hospitals; Kings County Hospital, including training school; Cumberland Street Hospital; Coney Island Hospital; and Farm Colony. There are omitted from the list as summarized, the administrative department, the Bureaus, and the Municipal Lodging House. In the Department of Bellevue and Allied Hospitals all of the Hospitals are included. In the Health Department no Hospital Helpers are employed, but for the purpose of

comparison all domestics, laborers, and orderlies were tabulated as corresponding in the main to the Hospital Helpers in the other two Departments.

The term "discharges" as used in this report includes all those having left the service either voluntarily or by dismissal.

Comparison by Years

Percentage of Discharges

The institutions in the Department of Charities during the year 1908 employed, on an average, 859 Hospital Helpers in the 9 lowest grades, from $60 to $180 per year. In 1911 in the same grades the institutions employed 990. During these 4 years the institutions had practically eliminated the 4 lowest grades, leaving in those grades but 3 employees, 2 at $60 and 1 at $96. In other words, the 38 positions in the 4 lowest grades in 1908 were dropped. In 1908 the $150 grade contained 259 and the $180 grade 77. In 1911 the $150 grade contained 358 and the $180 grade 312. The promotions from the lower grades to the higher, and also the increases in the number in the higher grades, did not materially change the percentage of discharges in the 9 grades. The number of discharges in these 9 grades during the year 1908 equaled 259 per cent. of those employed in these grades. During the year 1911 the discharges were 261 per cent., which is slightly higher than the percentage of discharges in the earlier year, which fact seems to indicate that the dropping of the lower grades and the increasing of the number in the higher grades did not reduce the percentage of discharges.

The Department of Bellevue and Allied Hospitals had no Hospital Helpers in grades under $180 per year during the 4 years, 1908-11. However, in the 4 grades, $180, $192, $216, and $240, this Department employed in 1908 423 Hospital Helpers, and in the corresponding grades in 1911 it employed 496. The number of Helpers in the $180 grade was reduced from 172 to 158; in the $192 grade the number was increased from 1 to 10; in the $216 grade the number was increased from 1 to 7; and in the $240 grade from 249 to 321, showing that there had been a gradual promotion from the $180 to the $240 grade; moreover, 73 Helpers were added, largely to the $240 grade. These promotions and additions to the higher grade, however, did not reduce the percentage of discharges during that period. In 1908 the discharges were 334 per cent. of the number employed in the 4 grades. In 1911 the discharges were 401 per cent. of those employed in these grades. In the $180 grade the percentage of discharges increased from 422 per cent. in 1908 to 515 per cent. in 1911. Although the number in the $240 grade had been increased by 72 the percentage of discharges in that grade was not decreased, but, on the contrary, was increased from 273 per cent. in 1908 to 351 per cent. in 1911.

Average Length of Stay of Those Leaving the Service

In the Department of Charities the average length of stay of Helpers during the years 1908-09 employed in all grades including $360 and below was 134 days. In 1910-11 the average length of stay for the same grades was 133 days. In 1908-09 there was an average of 526 employees in the grade of $144 and below, and in the period of 1910-11 this number had been

reduced to 374. The number taken from these lower grades was added to the higher grades. In 1908-09 there were but 712 in the grades ranging from $150 to $360, and in 1911 there were 1,020 in these grades. Since the average length of stay was 134 days in 1908 and but 133 days in 1911, it will be noticed that the shifting from the lower grades to the higher grades in these years under consideration actually reduced the average length of stay by 1 day.

In the Department of Bellevue and Allied Hospitals, the average length of stay of Helpers during the years 1908-09 in the grades from $180 to $360 was 90 days. In 1910-11 the average length of stay for the corresponding grades was 77 days. Within these 4 years the number of employees in these grades had materially increased. In 1908-09 in the grades from $180 to $216 there were 170 helpers. In 1910-11 this number was decreased by 5. On the other hand, the grades from $240 to $360 in 1908-09 had 330, and in 1910-11 these grades had been increased to 405. This marked increase in the number in the upper grades not only did not increase the average length of stay, but actually reduced it by an average of 13 days.

Comparison by Grades

A comparison by grades will throw light upon the Hospital Helper problem from another angle. In the following comparison the number of discharges per year in a particular grade is figured as the percentage of the average number in that grade for the year. For instance, if there were 50 in a grade and 100 left the service, these discharges would represent 200 per cent. of the number in the grade.

By 1911, in the Department of Charities, the $60, $72, $90, and $96 grades had practically been abolished. In order to ascertain the effect of these grades, when existent, upon the length of stay, it was necessary to go back at least 1 year. The year 1909 is probably more representative of the conditions existing before these grades were abolished. In that year, 1909, there were 241 per cent. of discharges in grade $60; 250 per cent. in grade $72; 183 per cent. in grade $90; 241 per cent. in grade $120; 255 per cent. in grade $144; and 280 per cent. in grade $150. These proportions very closely prevailed in the year 1910. It will be noticed that the percentages of changes were fully as high, and, in fact, somewhat higher, in grades $144 and $150 than in the lower grades, indicating that the larger amounts received by the Helpers in these grades did not reduce the percentage of discharges from the service.

In no grade below $180 was there a perceptible reduction in the percentage of discharges. In this grade, in 1909, there was 124 per cent. of discharges and in 1911 118 per cent. Here it will be noticed that the compensation of $180 apparently reduced the number of changes somewhat more than half. While the $180 grade in 1909 showed 124 per cent. of discharges, the $240 grade in the same year showed 202 per cent. In 1911 the $180 grade had 118 per cent. of discharges, while the $240 grade had 149 per cent. This difference in the percentage of discharges in the grades of $180 and $240 is observable in each of the 4 years 1908, 1909, 1910, and 1911. In no grade below $300 were the percentages of changes less than in the $180 grade. During the year 1909, in the $300 grade the discharges were 109 per cent.; in 1910 they were 111 per cent.; and in 1911 92 per cent. These percentages gradually decreased in the grades above $300.

As stated, the $240 grade in each of the institutions showed a larger percentage of discharges than the $180 grade. Such a showing was so unexpected that an effort was made to ascertain the cause of the higher grade showing also a higher percentage of discharges. It was suggested by some of the officials of the Department of Public Charities that possibly the fact that more women than men were employed in the $180 grade, and that the women were more constant in service than the men, would tend to make the percentage of discharges in the $180 grade less than in the $240 grade, which is composed more largely of men.

The number of discharges of males and females, calculated separately, was determined in these 2 grades as applied to City, Metropolitan, and Kings County Hospitals. In these institutions, in the $180 grade the males showed 104 per cent. of discharges, as compared with 130 per cent. for the females. In the $240 grade there was 209 per cent. of discharges among the males and 139 per cent. among the females. Inasmuch as the number of males and females was very nearly the same in the $180 grade, and the females showed a higher percentage of discharges than the males, the disparity between the discharges in the $180 grade and the $240 grade as observed in all institutions cannot be explained by the fact that a larger number of women are employed in the $180 grade and the assumption of greater constancy of service on the part of the women.

It is probable that the larger percentage of discharges in the $240 grade can be accounted for by the fact that the class of men in this grade is composed mostly of those who in former years occupied a higher position in life and received larger remuneration, while, generally speaking, the men employed in the $180 grade have always performed menial service and have not received materially higher compensation than they at present receive, and, therefore, they are more inclined to be satisfied with the pay given them. In other words, the $240 grade is more largely composed of men who have known better times and have become discouraged and despondent, and little inclined to render continuous service in any position that offers small compensation, whereas the $180 men are serving in a grade which they have in the main always occupied before entering the hospital service.

It seems fair to draw the conclusion that no grade above $60 secures a longer stay than maintains in that grade until the grade of $180 is reached, and the increases to the $192 and $216 grades do not secure a longer tenure than the $180 grade.

The facts noted above may be stated in another form, as follows: Of the total number having left the service during the years 1908-09, in the $60 grade 75 per cent. stayed less than 3 months, while but 17 per cent. stayed more than 6 months. In the $90 grade 62 per cent. stayed less than 3 months and 13.8 per cent. stayed over 6 months. In the $120 grade 68 per cent. stayed less than 3 months and 15 per cent. more than 6 months. In the $144 grade 71 per cent. stayed less than 3 months and 12.8 per cent. over 6 months. In the $150 grade 68 per cent. stayed less than 3 months and 15 per cent. over 6 months. It will be noticed that the percentages in the $150 grade were the same as in the $120 grade, and that the $120 and $90 grades did not differ materially from the $60 grade. In the $180 grade these percentages were reversed; 50.9 per cent. stayed less than 3 months, while 27 per cent. stayed over 6 months. Again, in the $240 grade it will be noticed that the results were less favorable than in the $180; 61.5 per cent. stayed less than 3 months and but 20 per cent. stayed over 6 months. Not until the $300 grade was reached were the percentages

again reversed. In this grade 46 per cent. stayed less than 3 months and 36.4 per cent. stayed over 6 months. It will be noticed that all grades under $180 seemed to have practically the same percentage of changes in the service.

In the Department of Bellevue and Allied Hospitals, as previously stated, there are no grades under $180. In the $180 grade the percentages of discharges in the years indicated were as follows: In 1908, 422 per cent.; in 1909, 501 per cent.; in 1910, 486 per cent.; and in 1911, 515 per cent. The $240 grade showed somewhat better results, as follows: In 1908, 273 per cent.; in 1909, 315 per cent.; in 1910, 387 per cent.; and in 1911, 351 per cent.

The $240 grade in Bellevue and Allied Hospitals likewise showed an improvement over the $180 grade when comparing the relative time of stay in these 2 grades for the years 1908-09. In the $180 grade 81.5 per cent. stayed 3 months or less, while but 7 per cent. stayed over 6 months. In the $240 grade 71.5 per cent. stayed 3 months or less, while 12.6 per cent. stayed over 6 months. A less improvement is noted in the years 1910-11. In this period, in the $180 grade 83 per cent. stayed 3 months or less and 7 per cent. stayed over 6 months, while in the $240 grade 81 per cent. stayed 3 months or less and 9 per cent. stayed over 6 months. The figures seem to indicate that the $216 grade secured somewhat better results than the $240 grade; in 1908-09, 58 per cent. stayed 3 months or less in the former grade and 12.5 per cent. stayed over 6 months, and in 1910-11, 75 per cent. stayed 3 months or less and 15 per cent. stayed over 6 months.

Comparison by Departments

A comparison of the Department of Public Charities with Bellevue and Allied Hospitals shows some results of interest.

As previously stated, Bellevue and Allied Hospitals, during the 4 years covered by the investigation of this subject, had no grades under $180. In that grade, however, the percentage of changes during the year 1908 was 422 per cent. The average percentage of changes for that grade and also including the 8 grades below it in the Department of Public Charities was but 259 per cent. In 1909 the percentage of changes in the $180 grade in Bellevue and Allied Hospitals was 501 per cent. In the 9 lowest grades in the Department of Public Charities during the year 1909 the percentage was but 243 per cent. In 1910 the percentage of changes in the $180 grade in Bellevue and Allied Hospitals was 486 per cent., and in the 9 lowest grades in the Department of Public Charities it was 260 per cent. A like comparison for the year 1911 shows 515 per cent. for Bellevue and Allied Hospitals, and but 261 per cent. for the Department of Public Charities. The noteworthy difference between these percentages seems to indicate very clearly that in the 9 lowest grades of the Department of Public Charities, the lowest of which is $60, the number of discharges is materially less than in the $180 grade of Bellevue and Allied Hospitals, which is the highest of the 9 lowest grades in the Department of Public Charities. It is also noteworthy that the percentage of changes in every grade from $180 to the highest, $720, is materially lower in the Department of Public Charities than in Bellevue and Allied Hospitals.

As previously stated, the average length of stay of those discharged by Bellevue and Allied Hospitals during the years 1908-09 in the grades ranging from $180 to $360 was 90 days, and in the same grades during the years 1910-11, 77 days. In the Department of Public Charities, the average length of stay for all grades, beginning at $60, up to and including $360, during the years 1908-09 was 134 days. In the same grades in 1910-11 the average length of stay was 133 days. Thus, it will be noticed that the average length of stay in the Department of Public Charities, including 8 low grades not existing in Bellevue and Allied Hospitals, was materially higher than in the Bellevue Department.

A similar disparity is apparent when the average length of stay of those remaining in the service December 31, 1911, is taken into consideration. Of those thus remaining in the service in Bellevue and Allied Hospitals 23 per cent. had remained over 6 months, while in the Department of Charities 69 per cent. had stayed 6 months or longer. In the $240 grade in Bellevue and Allied Hospitals 41 per cent. had remained 6 months or more, while in the Department of Public Charities 56 per cent. had stayed over 6 months. The percentages were somewhat more favorable to Bellevue in the $300 and $480 grades, but the number employed in these grades was too small to give a basis for a fair comparison.

Personnel Involved in the Dismissals and Resignations in the Hospital Helper Class

An endeavor has been made to ascertain the number of different individuals involved in the dismissals and resignations in the Hospital Helper class in the Department of Public Charities. The object of this inquiry was to determine to what extent persons at work had previously been employed in the Department, and through such employment had gained a knowledge of the work in the hospitals.

In the office of the Secretary of the Department is kept a card catalogue of all Hospital Helpers and on these cards are listed all changes in a position. This record would give full data as to the number of different individuals employed were it not for the fact that it is quite a common practice among those of the Hospital Helper class to reëmploy under different names. When it is discovered that a person is serving under a name not formerly used when employed in the Department an entry is made on the card under the name used in the original employment. It is probable that many of the names in this card catalogue list are aliases, and represent not different, but the same individuals. To what extent this may be true, it is impossible to determine.

The cards representing different individuals were checked by employees of the Committee and the total number of dismissals and resignations noted for the years 1908, 1909, 1910, and 1911. During these 4 years, according to the annual reports of the Department, there were 15,649 dismissals and resignations in all the institutions of the Department. The Department also states in its reports that 95 per cent. of these changes were among the class of help who received $20 and less per month. Since few Hospital Helpers receive more than this amount, the statement of the Department may, with reasonable accuracy, be applied to the Hospital Helper class as a whole. Deducting 5 per cent., there were 14,867 dismissals and resignations in the Hospital Helper class during the 4 years in the grades below $240. During this same period, according to the cards in the Secre-

tary's office, 8,467 different individuals had left the Department through resignation or dismissal. In other words, the dismissals and resignations were 78 per cent. greater than the number of persons employed as Hospital Helpers. It is altogether probable that this percentage should be considerably higher, owing to the fact, above stated, that the cards seem to represent more individuals than were probably employed.

On these cards also is recorded all changes in the Department. These changes, as listed yearly in the annual reports, are "Appointments, Promotions, Resignations, Transfers, Dismissals, Reductions." During the 4 years stated, according to the annual reports, there were 36,497 changes among all employees of the Department. This, reduced by 5 per cent., makes 34,672 changes occurring among Hospital Helpers in the grades below $240. According to the cards referred to above there were 9,987 different individuals involved in these changes during the 4 years. In other words, the changes were 347 per cent. of the Hospital Helpers employed. This indicates that in quite a measure the same individuals are involved in the total number of changes reported from year to year.

Graphic Presentation of the Preceding Data

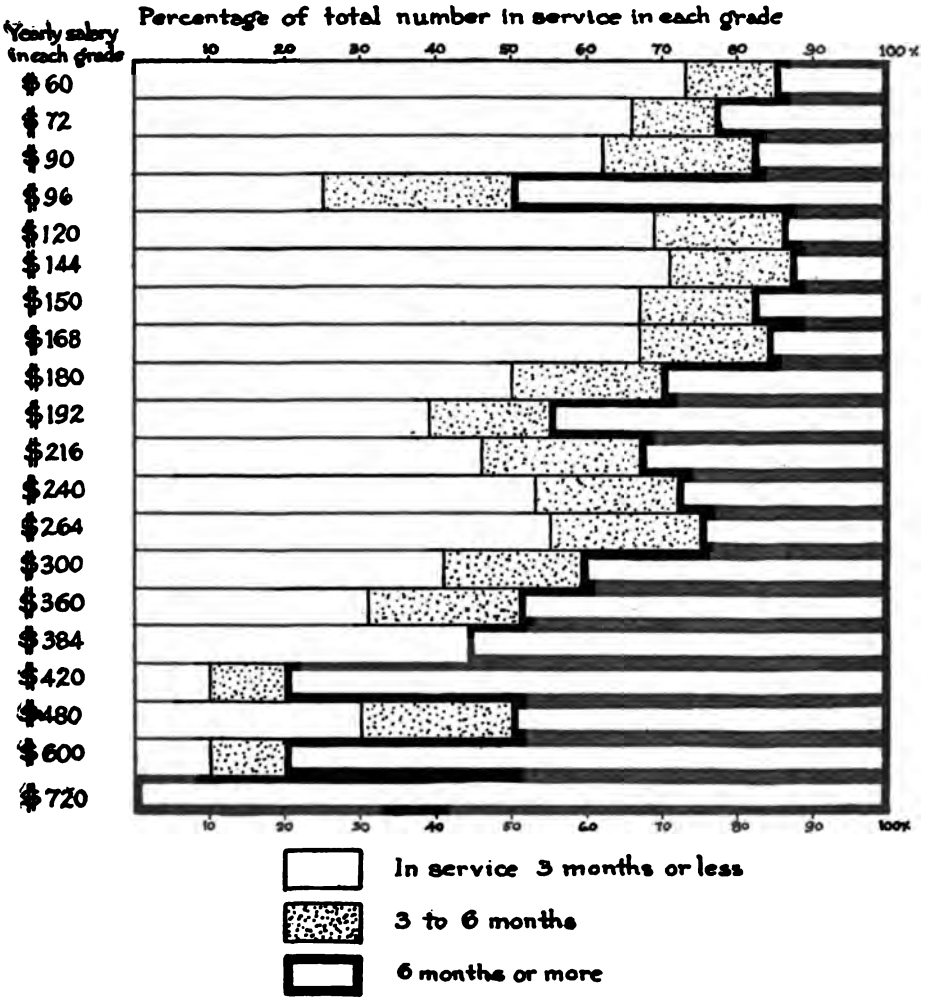
A graphic presentation of the data set forth in the preceding pages is contained in diagrams Nos. 1, 2, 3, and 4, on accompanying pages.

Diagram No. 1 shows the percentage of those employed in each grade in all institutions in the Department of Public Charities who worked 3 months or less; those who worked from 3 to 6 months; and those who remained more than 6 months. It will be noted that in the grades from $60 to $168 the percentage of discharges of those having served less than 3 months is practically the same for each grade. The $96 grade shows an exception to this statement. This exception is probably due to the fact that very few were employed in this grade. Not until the $180 grade is reached is there a notable improvement. Of the grades from $180 to $264, inclusive, each show about the same percentage of discharges, all being materially less than the preceding group. The grades beginning at $300 and upward show a gradual improvement in the percentage of discharges and length of stay. This diagram makes it apparent that an increase of pay from grade to grade from $60 to $168 does not decrease the percentage of discharges nor increase the length of stay. The same may be said for the group from $180 to $264, except that there is a notable improvement in the conditions of this group as compared with the former. The diagram makes it very apparent that the upper grades, beginning with $360, are much more constant in service.

Diagram No. 2 shows the ratio of those leaving the various grades, to the number of positions in such grades. It also makes a comparison on a like basis between the Department of Charities and the Department of Bellevue and Allied Hospitals. It will be noticed by referring to this diagram that the conditions in 1908 were very nearly the same as in 1911. Nearly the same percentages are shown in the corresponding groups for each period. In the Department of Public Charities the number of different persons employed in Grades $60 to $168 was 782 in 1908 and 678 in 1911, with an increase in pay of $5 per year in these grades between these periods. In grades $180 to $264 the percentages of discharges in the two periods were about the same, although the number employed in these grades

DIAGRAM 1

DEPARTMENT OF PUBLIC CHARITIES ALL INSTITUTIONS
COMPARATIVE LENGTH OF SERVICE IN THE DIFFERENT GRADES
COVERING A PERIOD OF FOUR YEARS, 1908-1911

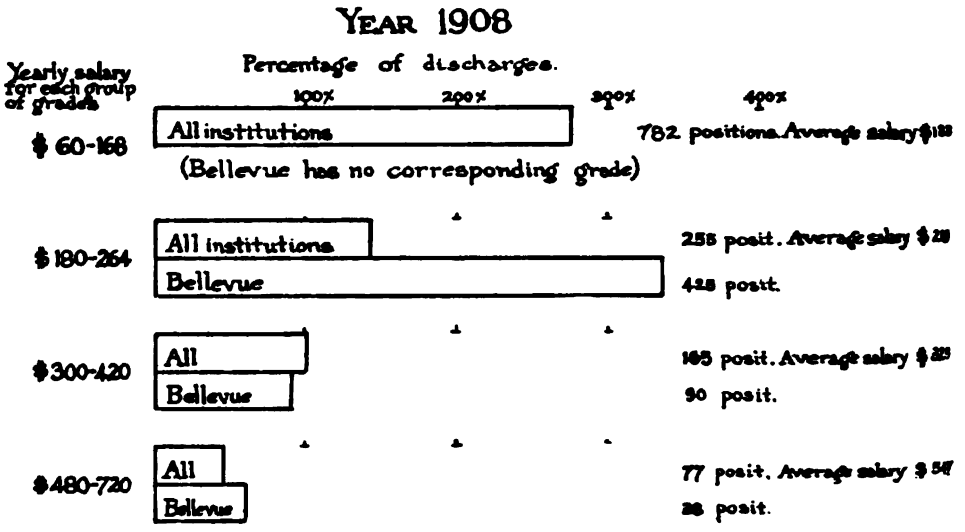


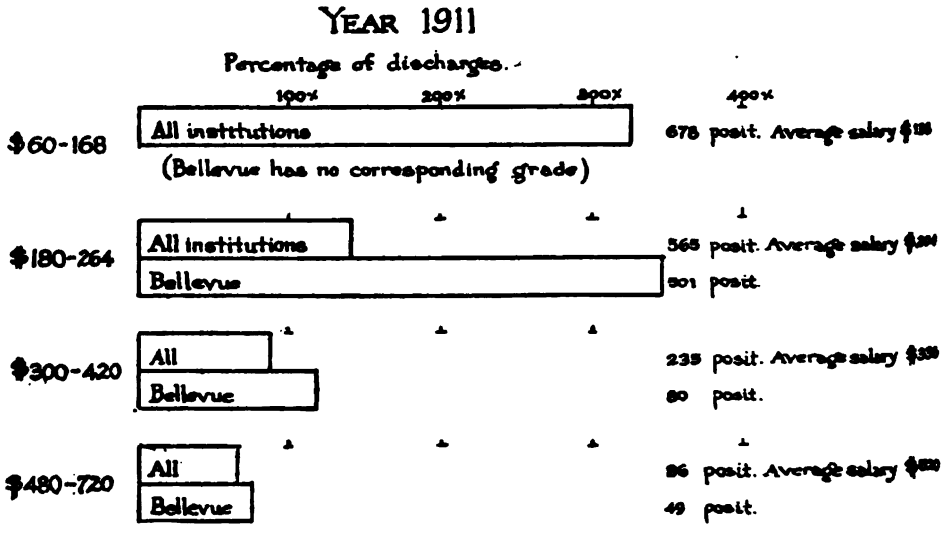
This diagram shows what per cent of those employed in each grade worked 3 months or less, from 3 to 6 months, and 6 months or more

DIAGRAM 2

ALL INSTITUTIONS OF DEPARTMENT OF PUBLIC CHARITIES COMPARED WITH BELLEVUE AND ALLIED HOSPITALS

RATIO OF NUMBER OF EMPLOYEES TO NUMBER OF POSITIONS





had increased from 255 in 1908 to 565 in 1911. Although the number employed had somewhat more than doubled in the 4 years, it had not materially changed the percentage of discharges. This condition would naturally be expected, since adding numbers to a particular grade should not affect the percentage of discharges in such grade if the number added to the grade were of the same class as those previously employed in that grade. The same facts may be noted in connection with grades $300 to $420. The number in these grades was increased during the period, but the percentage of discharges remained about the same.

It will be recalled that in Bellevue and Allied Hospitals none were employed under the $180 grade, but in this Department the percentage of discharges in the group of grades from $180 to $264 was somewhat larger than the grades $60 to $168 in the Department of Public Charities. This is true both for the years 1908 and 1911. On these facts being presented to some officials in both the Department of Public Charities and the Department of Bellevue and Allied Hospitals, the only explanation that was offered was that Bellevue, being situated on the mainland, where saloons were easily accessible, probably produced a larger number of discharges owing to drunkenness than would have occurred at the Island institutions in the Department of Public Charities. In order to analyze this suggestion a comparison was made between Bellevue and Allied Hospitals and Kings County Hospital, of the Department of Public Charities, located on the mainland in Brooklyn.

In Diagram No. 3 the comparison noted above between the percentage of discharges in Kings County Hospital and those in Bellevue is set forth. Kings County Hospital has more nearly abolished the grades under $180 than any of the other institutions in the Department of Public Charities, and may be said to occupy a position midway between the average in the Department of Public Charities and the condition existing in Bellevue. An examination of Diagram No. 3 will show that the percentage of discharges in each of the grades was somewhat less in Kings County Hospital than in Bellevue, though not so great a difference is shown as the average for the whole Department of Charities. This fact seems clear, however, that if the proximity of saloons produces a larger number of discharges, it did not produce as great an effect upon the employees in Kings County as in Bellevue.

It might be said that the larger number of discharges in Bellevue than in the institutions of the Department of Public Charities might be due to still other causes; namely, difference in administration, stringency of rules and regulations, or to the personnel of the supervising officers. In order to secure a basis into which these considerations might not enter it was deemed best to compare Bellevue with itself when it employed Helpers in grades under $180.

In Diagram No. 4 the above mentioned comparison is made. In 1903 Bellevue employed 108 Helpers in grades ranging from $120 to $150. In 1908 all of these grades had been dropped. By comparing the diagrams for these 2 years it will be seen that in 1903 the grades from $120 to $150 showed 430 per cent. of discharges; grades from $180 to $216, 350 per cent.; grades from $240 to $300, 120 per cent.; grades $360 to $480, 60 per cent. In 1908, previous to which time the lower grades had been dropped, the grades $180 to $216 showed 425 per cent. of discharges, as compared with 350 per cent. in the same grades in the year 1903. In 1908 the grades $240 to $300 showed 215 per cent. of discharges, as compared with 120

DIAGRAM 3

COMPARISON OF KINGS COUNTY HOSPITAL AND BELLEVUE HOSPITAL

COMPARATIVE LENGTH OF SERVICE IN THE DIFFERENT GRADES FOUR YEARS 1908 - 1911

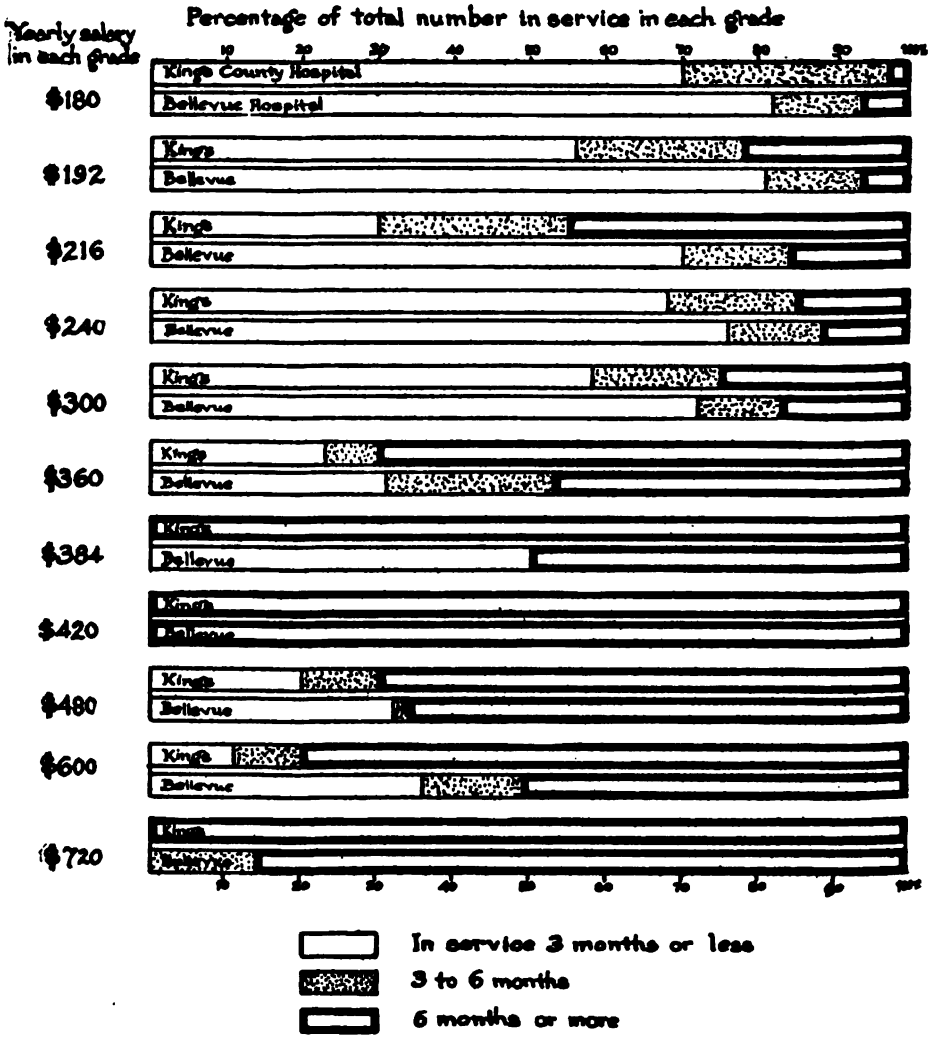
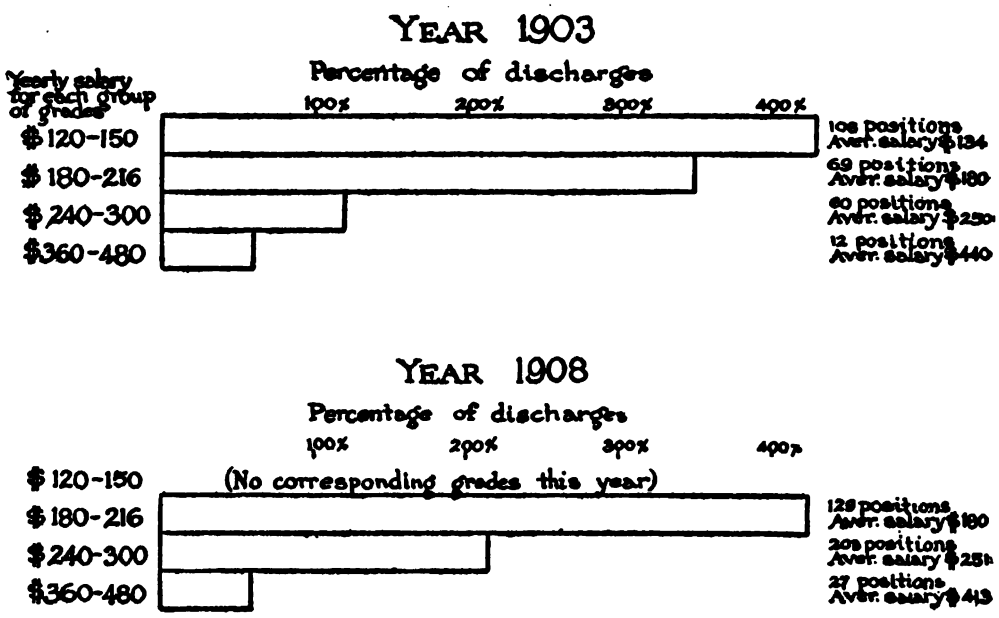


DIAGRAM 4

BELLEVUE HOSPITAL

RATIO OF NUMBER OF EMPLOYEES TO NUMBER OF POSITIONS

COMPARISON BETWEEN YEARS 1903 AND 1908



per cent. for the similar grades in 1903. It seems evident by these figures that the lower grades in 1903 acted as a buffer to the grades from $180 upward, and kept the percentage of discharges in those grades down. When, however, these lower buffer grades were abolished the grades from $180 upward increased, so that the percentage of discharges equaled the percentage noted in connection with the lower grades when they existed. It seems reasonably certain, therefore, that the class of Helpers formerly employed in grades from $120 to $150, when those grades were abolished, were promoted to the grades above; namely, those occupying the lower grades were probably promoted to grades from $180 to $216, and those occupying these latter grades in 1903 were promoted in 1908 to the grades from $240 to $300. That is, the abolition of the lower grades in Bellevue and the raising of the standard of pay did not decrease the percentage of discharges, but merely transferred and promoted the same class of persons serving in the lower grades into the higher grades, which transfer and promotion did not change their habits nor increase the constancy of their service. When, however, we compare grades $360 to $480, we find that they showed the same percentage of discharges in 1903 and in 1908. The abolition of the lower grades between these periods did not affect these higher grades. In other words, the class of persons serving in the lower grades, with few exceptions, did not reach these higher grades.

Dormitories and Food for Hospital Helpers

The food and lodging furnished Hospital Helpers are larger items in their compensation than the money given to them in the form of wages month by month. Many Hospital Helpers receive not to exceed $20 cash wages, and in addition to this, receive, in the form of food, lodging, and laundry, what probably amounts to not less than $25 a month. Food and lodging cannot be calculated solely on the basis of money value. Their character may contribute largely to the contentment or dissatisfaction of the Hospital Helper; as a matter of fact, the nature of the accommodations and food furnished probably do enter very largely into the regularity and constancy of the service of the Helper. It is highly probable that the City receives more service for the money it expends in dormitories and food than for that which it expends directly in the form of wages. A badly housed and poorly fed workman is apt to manifest his discontent by giving poor service, and by speedy desertion of his task.

The City should be able to furnish dormitory accommodations for Hospital Helpers at a cost not exceeding $600 per bed. (Details of this estimate are furnished in another section of the Report.) The annual carrying and repair charge, estimated at 5½ per cent. of this amount, would be $33 per year, or $2.75 per month. The Department of Public Charities has for years strongly urged that the wages of Hospital Helpers be increased from $120 per year to $240 per year, or an increase of $120 per year, being $10 per month. It is highly probable that better service would be secured by paying a lower wage and at the same time furnishing good sleeping quarters and food, than by paying a higher wage combined with poor accommodations and food. It is practically impossible to prove this assertion, owing to the many factors entering into the Hospital Helper problem. The situation in Kings County Hospital, however, seems to substantiate this theory. During the last few years the lower grades have gradually been dropped in Kings County, so that during the

year 1911 few Helpers were employed under the grade of $240. At the same time the sleeping accommodations have been worse than in any other hospital of the Department. Helpers have been housed in barn-like wooden structures, cold and uninviting, with the most meager bathing and toilet facilities, with practically no common lounging or reading room accommodation, and in practically all regards a very uninviting and unsatisfactory place in which to live and sleep. It seems highly probable that these poor accommodations have in quite a measure accounted for the fact that the percentage of discharges has been materially higher in Kings County Hospital than in the other institutions of the Department of Public Charities, regardless of the fact that the wages paid are materially higher in the former institution. These assumptions are supported by the testimony of a number of Hospital Helpers with whom the Committee's representatives have talked, and also by the Superintendent of Kings County Hospital, who states that not infrequently a Helper leaves the institution's service because of the poor dormitory accommodations.

If the City is to retain the lower grades of Hospital Helpers, as it seems necessary to do for some years to come, it would seem a warranted expenditure to furnish better dormitory accommodations than are at present provided. The additional expenditure would probably secure a greater regularity in the service and a higher grade of Helpers.

The food served to the Hospital Helpers is of good quality and sufficient in quantity. It is, however, neither well cooked nor well served in some of the institutions. Provision was made in the Budget for 1913 for higher pay for the head cook in each of the institutions and this should tend to correct the difficulty mentioned.

The dormitory accommodations in Metropolitan Hospital are reasonably satisfactory, or will be as soon as the new male dormitory now under construction is completed. The kitchen and dining room service, however, is exceedingly poor. In the service building now used are fed nearly all of the Hospital Helpers, besides the mechanics and clerks, in all about 375 daily, on a floor space of about 3,400 square feet, which indicates a serious overcrowding. The building is very old and badly out of repair, and of such character that repairs would not be warranted. A new service building should be erected as soon as possible.

The dormitory accommodations at City Hospital are reasonably good, except in the case of the male overflow dormitory, which furnishes accommodations for about 50 men. This is a one-story wooden building, with very inadequate bathing and toilet facilities. It should be replaced by a permanent building, but preferably not before the service building is built at Metropolitan Hospital and new dormitories at Kings County Hospital. The kitchen and dining room service at City Hospital is good. A new service building affords ample dining room space and good kitchen service. The cooking is acceptably done, and there should be no ground of complaint on the part of the Helpers as to the character of food or service.

The dormitory accommodations for Helpers at Kings County Hospital are very poor and inadequate. The orderlies are quartered in the old nurses' home, which is a satisfactory dormitory in the matter of space, and toilet and bathing facilities. The clerical help is housed in the building known as the "Stewart Building," built for the male insane, which is still in a fair condition of repair, and furnishes acceptable accommodation. The dietitian, kindergartner, and some attendants are housed in the building

originally built for female insane, corresponding in accommodation to the Stewart Building. Some of the female attendants are quartered in the building formerly intended for isolation purposes, which serves very acceptably its present purpose, except for the lack of toilet facilities. About 40 men and 29 women are accommodated in two one-story wooden pavilions, divided into small rooms by means of wooden partitions, with 2 beds in a room, and with extremely meager toilet and lavatory facilities. There is no common sitting or reading room, and the whole atmosphere of the place is depressing. About 17 ward-maids are quartered in the basement of the main building, which space should be devoted to hospital rather than dormitory purposes. Accommodations for Helpers are also provided on the first floor of the main building, where about 19 are provided with sleeping quarters. This space should be devoted to hospital purposes rather than to the sleeping quarters of the help. About 23 Helpers are quartered in the new nurses' home, which space will be needed for additional pupil nurses. About 40 Helpers now sleep at home who should be quartered at the Hospital. The 168 Helpers above noted should be provided for in new dormitories, and when these dormitories are built they should furnish accommodations for not less than 200, to provide for the additional help required for the new children's pavilion, and the new wing which is soon to be built.

The male Helpers at Children's Hospital and Schools on Randall's Island are quartered in a three-story brick building which provides sufficient dormitory and toilet accommodations. The female help is quartered on the upper floors of what is known as the laundry and kitchen building. In these dormitories no provision is made for space for clothing, except in boxes under the beds. The toilet and lavatory facilities are very inadequate and no bathing facilities are furnished for about 50 women. About 100 Helpers must use the toilet and bathing facilities contained in 2 rooms about 12 by 12 feet in size. The plumbing is old and unsanitary, and the entire building is in a bad condition of repair. The seamstresses are housed in the Infants' Hospital, which space should more properly be used for patients. Dormitory accommodations for the women are very urgently needed. The dining room accommodations are reasonably satisfactory, and any improvement in this service should be postponed until additional dormitory accommodations are provided.

2. PROPOSED SALARY AND WAGE SCHEDULE FOR THE DEPARTMENT OF PUBLIC CHARITIES

THE INVESTIGATION

Your Committee has endeavored to standardize the wages and salaries in the institutions of the Department of Public Charities. This phase of the work was begun in June, 1912, and, inasmuch as it was desired that the budget which would be considered in the following October should be based upon such standardization, it became necessary to restrict the work to a limited number of institutions. The institutions standardized are the following:

Metropolitan Hospital
City Hospital
Kings County Hospital
Home for the Aged and Infirm, Manhattan
Home for the Aged and Infirm, Brooklyn
Farm Colony

The method pursued was to interview the various heads of departments; examine the tasks in each of the institutions; ascertain the number employed on particular tasks; the character of the employees; length of time in the particular institution; and the opinion of the one interviewed as to the probable effect of an increase or decrease of wage on the standard of service. The payroll was then checked and detailed information recorded with regard to each employee; setting forth the time of entering the service, character of work performed, and wage or salary. In gathering such information the work of the institution was divided into about sixty tasks, and the number noted in connection with each task. Subsequently, similar tasks were compared in the different institutions to ascertain the comparative number employed in the performance of such tasks. Where the work corresponded to work in the commercial field opinion was secured as to wages and hours in such commercial work. This applied especially to stenographic work and telephone service.

The information gained in connection with an examination of the Hospital Helper service was used in connection with establishing the wage schedule. One of the conclusions reached in the former examination was that it was deemed advisable to retain a grade of $120 per year, and to automatically promote those having served in that grade 3 months to a $180 grade, irrespective of other qualifications, on the assumption that any Helper who had remained in his position for a period of 3 months had demonstrated that he was worth the additional amount provided in the next higher group. The arguments for retaining the grades of $120, $180, and $240 have been set forth on preceding pages. The schedule provides that all promotions, except the one noted above, are to take place only after a year's service (except in the $180 and $240 grades, where 2 years are required), and on recommendation of the Commissioner, based on the efficiency of the service rendered.

It was deemed advisable to draw a distinct line between the class to be called Hospital Helpers and those who would be listed under a title. It is recommended that all employees receiving $480 or less be called Hospital Helpers, and all receiving more than that amount be employed by title.

In the plan proposed the employees are divided into grades, 13 in number, and each grade is subdivided into groups. Group "A" provides for the highest salary that can be secured in any grade after service has been rendered in the group or groups below. Length of service necessary for promotion may be reckoned in the Department as a whole, not in any particular institution, thus making it possible to transfer from institution to institution without sacrifice of grade-standing.

The rate of increase of wage or salary is $60 per year in the first 7 grades. Grades VIII to XI provide for a graduated increase yearly of $120 per year. Grades XII and XIII provide for a larger and arbitrary yearly increase, not based upon the divisibility of such amount by 12, or the number of months in a year.

Aside from providing that like work shall receive like wages or salary throughout the institutions of the Department, and also a basis of promotion for length of service, the principal changes to be effected by the Salary and Wage Schedule as presented are as follows:

1. A line will be drawn, below which all employees are Hospital Helpers and above which all are distinctive titled positions.
2. The wages of all those serving patients or working in wards will be raised, with the hope that such increased pay will secure a better class of employees.
3. Some positions of marked responsibility, such as Pharmacist and Head Cook, will be materially increased.

The adoption of this schedule providing for yearly promotion will probably not require a materially larger annual appropriation than that provided in the budget of 1913 [1] for a like number of employees.

About 70 per cent. of those serving in Grade I, constituting a large proportion of the employees of the institutions, will probably remain in the $120 group. There was about the same number in this group in the 1913 budget.

About 70 per cent. of those in Grade II will probably remain in the service less than 6 months; that is, not to exceed 30 per cent. of those in this grade will serve in the $240 group. The budget for 1913 provided approximately this proportion of employees in the $180 and $240 groups.

The lowest group of Grade III is $240. In this group it may be expected that about 70 per cent. will serve less than 6 months; that is, not to exceed 30 per cent. of those serving in this grade may be expected to reach the $360 group of the grade. In the budget for 1913 more than 30 per cent. were in the highest group of this grade.

In Grade IV about 50 per cent. of the employees in each of the 3 groups—$360, $420, $480—may be expected to leave the service each year. At this ratio, within 3 years about one-third of the employees would be in each of the groups, so that the $420 group would represent the average for the grade. In the budget for 1913 slightly less than one-third of the employees in this grade were in Group "A," and nearly two-thirds were in Group "C," comparatively few having been placed in Group "B." Since a portion of Group "C" will be promoted to Group "B," with an increase of $60 per year in salary, the appropriation necessary to provide for the employees in this group will have to be somewhat increased. It is probable

[1] This report was completed before the budget of 1914 was made up, but inasmuch as it was not submitted to the Board of Estimate and Apportionment its recommendations did not enter into the 1914 budget.

that it may require $4,000 or $5,000 to provide for the promotions in this grade in the budget of 1914.[1] Thereafter, those in this grade leaving the service should approximately balance the promotions which would take place in the grade. Thus an equilibrium would be established by the budget of 1914 which would thereafter be maintained.

The number of employees in the title grades from VI to XIII are a small proportion of the total number employed in the institutions, and, inasmuch as a good proportion of these were placed in the highest group of their respective grades by the budget of 1913, it is improbable that the promotions provided for in the schedule will require materially larger appropriations in subsequent years than in the budget for 1913.

If this schedule is adopted, it is probable that not more than from $5,000 to $10,000 additional to the budget for 1913 will be required to provide for the promotions incorporated in the schedule.

Definition of Certain Services

With few exceptions the titles in the following Wage and Salary Schedule sufficiently describe the character of the positions and the work connected with each. It seems desirable, however, to define somewhat more fully the functions of the following positions:

Attendant or Orderly. The term "Attendant or Orderly" is intended to apply either to a male or female caring for patients under the supervision of a trained nurse or trained attendant. The character of service which may be performed for patients by an Attendant or Orderly is to be subject to definition and regulation by the Superintendent of the hospital.

Ward Cleaner or Wardmaid. A Ward Cleaner or Wardmaid is to have the duty of cleaning wards and accessory rooms; to move beds and stretchers; to make beds when required; but to perform no service with or for patients.

Payroll Clerk. A Payroll Clerk as listed in Grade VIII is intended to fulfill the duties of the Chief Clerk of an institution where the store room books are not kept by a Steward. His functions should involve not only the making out of payrolls, but also the supervision of all records and reports.

Assistant Payroll Clerk. The position of Assistant Payroll Clerk is intended to include only the making out of the payrolls and the performance of other incidental work assigned by the Payroll Clerk or Superintendent. The function of supervising the general records of the institution when an Assistant Payroll Clerk only is employed, is supposed to reside in the Superintendent.

Mechanician. A Mechanician is an employee familiar with, and able to operate and keep in repair, simple forms of machinery.

Salary and Wage Schedule

All salaries herein stated are based on maintenance at the institutions. When deemed necessary and advisable the Commissioner of Charities may permit any employee receiving $480 or above to take a portion or all of

[1] See footnote about 1914 budget on page 570.

his maintenance away from the institution. In an institution where the dormitory accommodation is not sufficient for all employed, the Commissioner may grant maintenance allowance to such persons as cannot be maintained at the institution. In case such exemption is made, in lieu of maintenance and laundry an employee should receive, in addition to his salary, five dollars per month for the particular meal of the day not eaten in the institution and five dollars per month for lodging not had in the institution. In the annual estimate, the Commissioner of Charities should insert a separate item for such outside maintenance, specifying the amount for each position.

In Grade I promotions are to take place automatically at the expiration of the term of service indicated.

Except in Grade I, all promotions are to be made on the basis of efficiency, but only after service has been rendered for the period indicated in the various grades and groups. Promotions are to be made by the Commissioner of Charities on recommendation of the superintendent of the institution in which such promotion is desired.

All persons entering Group B of Grades I and II are to be required to serve a probationary period of 1 week without pay other than maintenance.

Promotions may be made to the lowest group of a higher grade, on merit, only after the person to be promoted has served in Group A of the grade from which promotion is to be made.

The Civil Service Commission is to be notified of all changes in position or personnel in all grades above Grade I, such notification to include the title of the position as listed in this Salary and Wage Schedule.

Appropriations for Grades I, II, III, and IV are to be made in blanket amounts, and those employed in these grades to be known as Hospital Helpers.

GRADE I. To include those performing unskilled labor not in quarters occupied by patients, or light work capable of being performed by old persons; a class of work involving little responsibility, where change of personnel could be made with comparative frequency without materially affecting the work in hand, such as:

Bathroom Helper
Barber's Helper
Butcher's Helper
Caretaker, for patients' clothing
Carpenter's Helper
Cleaner, for floors, windows, etc.
Clerk, for routine duties
Clockman
Coal Passer
Crematory Helper
Dish Washer
Dockman
Driver, for work or delivery carts or wagons
Electrician's Helper
Floder
Groundman
Ice Plant Helper
Ironer
Kitchen Helper
Laundry Machine Operator
Laundry Helper
Locksmith
Mason's Helper
Morgue Helper

Painter's Helper
Pantrymaid
Pantryman
Plasterer's Helper
Plumber's Helper
Pharmacist's Helper
Porter
Runner
Sexton
Seamstress
Shoe Repairer
Sorter
Stable Worker
Steam-tableman
Sterilizer
Storehouse Helper
Tailor's Cutter
Tinsmith
Tub Washer
Vegetable-man
Waiter or Waitress, other than in Grade II

Salary. Group B. Those having served less than three months..... $120
Group A. Those having rendered consecutive service in the Department and in the next lower group for a period of three months or more..... 180

GRADE II. To include those performing unskilled work, yet requiring a certain degree of responsibility and somewhat more constancy of service than provided for in Grade I. Persons serving in this grade may perform manual or physical work in connection with ward service, but should have no direct care of patients, such as:

Boilerman
Chambermaid
Counterman
Elevator Attendant
Food Runner
General Service-girl
Laboratory Assistant, Clinical
Laundryman's Helper
Letter Carrier
Porter, in nurses' homes, to begin service in Group "A"
Tailor
Telephone Operator, Night, in hospitals having no night emergency ambulance service
Ward Cleaner
Wardmaid
Ward Kitchenmaid
Waiter or Waitress, serving in staff house and nurses' homes, to begin service in Group "A"

Salary. Group B. Those serving in the Department less than one year..... $180
Group A. Those having rendered consecutive service in the Department and in the next lower group for a period of one year or more..... 240

GRADE III. To include those having manual trades, but working largely on repairs; and those from whom honesty and reliability may be expected, but not involving much supervision or oversight of subordinates, such as:

Attendant or Orderly, for helpless inmates in almshouses
Bathroom Attendant in Charge, in almshouses
Barber
Carpenter
Clerk, in linenroom
Clerk, in medical record office
Cook, Night
Cook, Plain
Counterman, Chief, in storeroom of institutions or wholesale general store

Electrician, Assistant
Engineer's Helper
Foreman, Assistant
Gardener, Assistant
Housekeeper or Cook, for officers and chaplains
Housekeeper, in charge of cottages in almshouses
Housekeeper, Assistant
Janitor
Laundress, Assistant
Laundress, First Assistant, in almshouses
Mason
Mattress and Mattress-spring Maker
Mechanician, Assistant
Morgue Keeper, delivering bodies to other morgues
Office Assistant
Painter
Pharmacist's Assistant
Plasterer
Plumber
Sorter's Assistant
Sorting-room, Foreman of, in the laundry
Stables, Foreman of, serving one or two institutions
Telephone Operator, Day, in almshouse
Waiter, Head, in hospitals, serving less than 500 persons
Waiter or Waitress, Head, in almshouses
Waiter or Waitress, serving in general administration officers' quarters, to begin service in Group "B"

Salary. Group C. Those serving in the Department less than one year..... $240
Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years..... 300
Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more..... 360

GRADE IV. To include those from whom constancy of service should be expected, and on whom responsibility can be placed for accuracy of work; or those having ability to oversee or supervise a limited number of persons, but not involving much skill or education in any particular line, such as:

Admitting Office Clerk
Attendant or Orderly, in hospital
Baker, in almshouse
Butcher
Clerk, General
Cook, Head, in kitchen in staff houses and nurses' homes
Cook, First Assistant, in kitchens serving 500 or more persons
Cook, serving in general administration officers' quarters, not to be promoted beyond Group B
Copyist
Driver of Motor Trucks
Driver of Horse Ambulance
Driver, for work or delivery carts or wagons making periodic deliveries to other institutions
Gardener in Charge, for grounds of not more than two institutions
Housekeeper
Laboratory Assistant
Laundry, First Assistant, in hospitals
Laundress or Laundryman in Charge, in almshouses
Linenroom, Head of
Matron, Assistant
Mechanic, serving more than one institution
Mechanician
Morgue, Keeper of General
Medical Record Office, Head Clerk

Payroll Clerk, Assistant
Seamstress in Charge
Supervisor, Assistant, in almshouses
Telephone Operator, in hospitals with 200 or more beds and night emergency ambulance service
Waiter, Head, in hospitals, serving 500 or more persons
Watchman
X-ray Operator, Assistant

Salary.	Group C. Those serving in the Department less than one year	$360
	Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years	420
	Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more	480

NOTE: The persons serving in the following grades to be estimated for by title; the number under each title and group to be stated.

GRADE V. To include those performing certain kinds of services requiring specialized training as listed, such as:

Auto Engineman	$ 960
Chaplains	450
Deputy Lay Superintendent	1,000
Internes, Tuberculosis Service, Junior	240
" " " Senior	300
" " " House	360
Psychopathic Service, Attendant, Head	600
" " Trained Nurse, Supervising	720
" " " " Head	600
" " Special Officer	720
Pupil Nurse, 1st year	120
" " 2d "	144
" " 3d "	180
Superintendent of School for Nurses	1,800
Superintendent of Nurses	1,200
Trained Nurse, Head, in operating room	840
" " Supervisor:	
Those serving in the Department less than one year	720
Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years	780
Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more	840
" " Head:	
Those serving in the Department less than one year	600
Those having rendered consecutive service in the Department and in the next lower group for a period of one year or more	660
" " Post Graduate	300

GRADE VI. To include those of responsibility, performing services requiring a certain degree of technical education; or those of sufficient training to take charge of the workers in a division, such as:

Baker
Cook, Head, in almshouses
Counterman, Head, in retail general store
Dietitian
Dietitian, Assistant
Engineer, Chief, where plant serves less than 300 beds, or serving a low pressure plant, to be known as Class 4
Engineer, Assistant, serving with Class 3 Chief Engineer
Foreman of Laborers

Gardener in Charge, for grounds of more than two institutions
Instructor, not under the Department of Education
Laundryman or Laundress in Charge
Matron, of almshouses, having charge of more than 300 and less than 900 inmates
Matron, in hospitals, having general oversight and performing duties of dietitian
Oiler
Pharmacist, Assistant
Social Service Worker, Assistant
Supervisor, Second Assistant
Supervisor (male), of almshouses, having charge of more than 300 and less than 900 inmates
Stables, Foreman of, serving more than two institutions
Stenographer
Stoker
Tailor

Salary.	Group C. Those serving in the Department less than one year.....	$600
	Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years.....	660
	Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more.....	720

GRADE VII. To include those capable of taking charge of a department; or one in a position of large responsibility in a smaller institution; or an assistant to a position of large responsibility in the larger institutions of the Department; or one in charge of a large number of patients or inmates; or one in charge of work requiring not only several years of specialized and general training, but also some years of experience in practical work, such as:

Baker, Chief
Cook, Chief, in hospitals, cooking for not less than 500 persons
Engineer, Assistant, serving with Class 2 Chief Engineer
Engineer, Chief, where plant serves 300 or more and less than 600 beds, to be known as Class 3
Matron, in almshouses, having charge of more than 900 inmates
Hospital Clerk
Social Service Worker, Head
Supervisor, Assistant

Salary.	Group C. Those serving in the Department less than one year.....	$780
	Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years.....	840
	Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more.....	900

GRADE VIII. To include the following positions:
Deputy Superintendent of Training School
Engineer, Chief, where plant serves 600 or more and less than 1,500 beds, to be known as Class 2
Engineer, Assistant, serving with Class 1 Chief Engineer
Pharmacist
Storekeeper, First Assistant, in store serving three or more institutions
Steward
Supervisor, acting in the capacity of Lay Deputy Superintendent
X-ray Operator

Salary.	Group C. Those serving in the Department less than one year.....	$960
	Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years.....	1,080
	Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more.....	1,200

Grade IX. To include the following positions:
Alienist, Second Assistant
Director of Laboratory, Assistant
Electrician, in charge of institution lighting plant
Engineer, where plant serves 1,500 or more beds, to be known as Class 1
Pathological Chemist

Salary. Group B. Those serving in the Department less than one year..... $1,320
Group A. Those having rendered consecutive service in the Department and in the next lower group for a period of one year or more..... 1,440

Grade X. To include the following positions:
(No one at present included in this grade)

Salary. Group C. Those having served in the Department less than one year.... $1,560
Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years..... 1,680
Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more..... 1,800

Grade XI. To include the following positions:
Alienist, First Assistant
Medical Superintendent, Deputy
Superintendent, in almshouses

Salary. Group C. Those serving in the Department less than one year..... $1,800
Group B. Those having rendered consecutive service in the Department and in the next lower group for a period of one year and less than two years..... 1,980
Group A. Those having rendered consecutive service in the Department for a period of two years or more and in the next lower group for a period of one year or more..... 2,100

Grade XII. To include the following positions:
Alienist, Resident
Director of Laboratory, serving hospitals having jointly from 10,000 to 25,000 admissions yearly

Salary. Group B. Those serving in the Department less than two years..... $2,700
Group A. Those having rendered consecutive service in the Department and in the next lower group for a period of two years or more..... 3,000

Grade XIII. To include the following positions:
Director of Laboratory, serving hospitals having jointly more than 25,000 and less than 35,000 admissions yearly
Superintendents, Medical or Lay, for hospitals having 500 or more and less than 1,000 bed capacity, exclusive of tuberculosis service

Salary. Group B. Those serving in the Department less than two years..... $3,500
Group A. Those having rendered consecutive service in the Department and in the next lower group for a period of two years or more..... 4,000

Section IX.—FOOD, BUILDINGS, AND CONTROL FORMS

1. Handling of Food and Food Waste
2. Character and Costs of Hospital Buildings
3. Internal Control Forms Suggested for Bellevue Hospital

1. HANDLING OF FOOD AND FOOD WASTE

FOREWORD

A limited examination has been made of the methods of handling food in the three Departments under investigation. Inasmuch as the Board of Estimate and Apportionment has established certain specifications for food, and the Comptroller's Department stations men at the institutions to compare food received with the specifications, and also to check the same deliveries on the invoices, it was deemed unnecessary to inquire into this phase of food-handling. The inquiry has been confined to an examination of the proportions of different kinds of food used; the method of requisitioning food from the Storehouse; the method of serving food; and the methods used to regulate the amount of waste.

An inquiry into the methods of controlling waste was made in Bellevue Hospital only. Owing to a lack of time it was impossible to make such an inquiry in all of the hospitals, and Bellevue was chosen for this purpose because of the full and cordial coöperation on the part of the Hospital officers. Although this phase of the inquiry has been almost entirely confined to Bellevue Hospital, it is reasonable to assume that uncontrolled waste is quite as prevalent in the hospitals of the Department of Charities, since in that Department the gross amount of meat served to a small summer census was as much as that served to the large winter census, which would seem to indicate that there was a waste of food during the summer, or that the patients were underfed during the winter.

The amounts of food used in the different hospitals have been set forth in tables, which contain all of such items, with the exception of fresh fruits, fresh vegetables, and cooking accessories. These were omitted because such omissions were found best in arranging a table similar in form to the one herein shown for use in determining the amount of food consumed in the State institutions of New York, Indiana, and Iowa, by your Director, and published in a report entitled "Fiscal Control of State Institutions." In that investigation it was necessary, when comparing State institutions, to exclude fresh fruits and fresh vegetables, owing to the fact that some of the institutions produced large quantities of these foods, and were not accurate in their account of the amount consumed. Inasmuch as these two classes of food omitted are a small proportion of the total amount of food used, their omission does not materially condition the statement of the aggregate amount of food used by each institution. By their omission in the tables setting forth the food used by the City institutions it was possible to make a comparison between the institutions of New York City and the State institutions in the three States indicated.

Comparatively little attention has been given in public institutions, here or elsewhere, to methods of controlling food waste. One instance of a systematic and well-conceived effort along this line occurred in connection with the State Hospital at Kings Park, Long Island. At the suggestion of your Director a system was installed at that institution in the fall of 1910,

and, with some modifications and enlargements, has been in successful operation since that time. It has produced noteworthy results and marked savings to the institution, accompanied by better feeding of the patients and employees, and hearty coöperation on the part of employees in kitchens and dining rooms. Inasmuch as practically no systematic consideration of food waste has been given in the institutions of New York City it has been deemed advisable to describe the method and results in Kings Park State Hospital (page 603), for the purpose of stimulating similar efforts in our municipal institutions.

THE INVESTIGATION

Bellevue and Allied Hospitals

The food used in the Department of Bellevue and Allied Hospitals is purchased by the General Purchasing Agent, located at Bellevue, and all of the food under contract is delivered to the storehouse at Bellevue, from which supplies are transferred to the allied hospitals. This includes all food used, with the exception of fresh fruits and fresh vegetables. Except for local conditions, which might include racial preferences or prejudices for or against certain kinds of food, it might be assumed that the proportions of the various kinds of food in the different hospitals of the Department of Bellevue would be practically the same. This, however, is not the case.

By referring to the tables on pages 612 to 615 it will be observed that of meat Bellevue used 344.8 pounds per capita per year; Harlem 372.5; Gouverneur 319.6; and Fordham 393.6. As a detail of this, it will be noticed that Fordham Hospital used 84.2 pounds of mutton per capita per year, whereas Gouverneur Hospital used but 44.1 pounds, with Harlem Hospital following midway between with 62.6 pounds per capita per year. Gouverneur used 4.8 pounds of pork per capita, as compared with 16.1 pounds used by Fordham, and about 11 pounds each for Bellevue and Harlem Hospitals. This smaller amount for Gouverneur Hospital was due to the predominance of patients in that hospital who use pork in very limited quantities. This being so, it might naturally be expected that Gouverneur would use a larger proportion of mutton or beef than the other hospitals, which, however, is not the case.

A marked difference is noted in connection with the use of poultry. Bellevue used but 42 pounds per capita per year; whereas Harlem Hospital used 79.5 pounds; Gouverneur 47.5 pounds; and Fordham 83.4 pounds. A marked difference in the amount of milk is noticed, namely: Bellevue used 589 pounds per capita per year; Harlem Hospital 733 pounds; Gouverneur Hospital 658 pounds; and Fordham Hospital but 547 pounds. It might be supposed that the hospital that used the least milk might use more eggs as a substitute, but Fordham Hospital, showing the least consumption of milk of the four hospitals, used but 56 pounds of eggs, whereas Gouverneur Hospital, with a consumption of milk of 658 pounds, used 89 pounds of eggs per capita per year.

Not only did the items of food vary in the different hospitals of the Department of Bellevue, but there was, as a result, a variation in the amounts of total protein and calories supplied the patients and employees. The daily per capita amount of protein represented in the food furnished to Bellevue Hospital was 122.3 grams, and of calories 3,240 per capita per day; in Harlem Hospital 126.8 grams and 3,373 calories; in Gouverneur 119.8 grams and 2,959 calories; in Fordham Hospital 124.6 grams and 3,356 calories. It will be noticed that Gouverneur Hospital was somewhat behind the other hospitals, both in the amount of protein and calories supplied.

Requisitions for Food Supplies from the Storehouse

When it was discovered that the proportions of the different kinds of food in the allied hospitals of the Department of Bellevue varied to a certain extent an investigation was made to determine the method of requisitioning by the allied hospitals from the main storehouse at Bellevue. It was found that each hospital is permitted to make its requisitions without any statement having been issued to such hospital as to the total amount of food which it is permitted to use within given periods, or the proportions of the total amounts which it would be expected to requisition. When the requisitions reach the Dietitian at Bellevue they are passed upon without any knowledge on the part of the Dietitian as to the number of people in the hospital making the requisition. No daily or weekly census is furnished to the Dietitian, and the Dietitian, accordingly, has no basis on which to judge the adequacy or inadequacy of the amount of food requisitioned. Under these circumstances it is surprising that the per capita amounts of different kinds of food varied as little as indicated by the tables referred to.

Meats are contracted for quarterly by the Contract Clerk at Bellevue. The estimate of the amount needed is not based upon any data furnished by the Dietitian, and the Dietitian is not consulted by the purchasing department with regard to the total quantity or the proportions of food required, as the estimate is made in the accounting department and is based upon the amount of food used in previous periods. In other words, the accounting department is interested in the determination of the amount and kinds of food used, and the Dietitian, who is primarily interested in the feeding of the patients, has no part in such determination.

Contracts made for State institutions provide that the institutions may order "more or less, or, as may be required for the use of the institutions for the time specified." This provision enables the institutions to vary the amount actually purchased, according to the fluctuation of the census. The contracts entered into by Bellevue may reduce the contract amount by 5 per cent., but may not increase it. As a result of this narrow margin, or leeway, Bellevue has purchased practically the total amount of its various contracts for food.

Requisitions Not Based upon the Census

Requisitions for food supplies are made out by the Dietitian, approved by the Assistant Superintendent, and filed by the Storekeeper. These requisitions are not based upon the census day by day; nor, apparently, are they based upon the change of the census month by month, or season by season.

During the first half of 1912, ended June 30, the average weekly use of meat and fish for the patients alone amounted to 4,671 pounds. During this period the average daily census of patients was 1,324. During the second half year, ended December 29, 1912, the average weekly delivery was 4,733 pounds, while the average daily census was 1,171. Thus, it will be noticed that more meat was used in the gross when the average census was 1,171 than during the first half of the year, when it was 1,324. The highest daily average census was during the week ended April 28, 1912. The average daily amount of meat per patient served during that week was .48 pound. If it be assumed that the patients were well and sufficiently fed on the allowance provided for that week, and this same ratio were applied throughout the year, Bellevue would have used 217,774 pounds of

meat and fish for the patients, instead of 244,289 pounds, which were actually used. Thus, there were served to the patients 26,515 pounds of meat and fish more than would have been served if the ratio used in the week ended April 28 had been maintained; which was approximately the same ratio as was maintained for the months of March, April, and May.

The failure to adjust the requisitions to the shifting census was noted in connection with the use of eggs, as well as in connection with meat. During the months of March, April, and May, 1912, Bellevue requisitioned and used an average of 9,708 dozen eggs per month. In these months the average daily census of patients was 1,337. During August, September, and October an average of 9,740 dozen eggs were used monthly. The average daily census of patients in this period was 1,159. Thus, it will be noticed that more eggs in the gross were used for 1,159 patients than for 1,337.

During the year 1912 Bellevue used 94,926 pounds of fowl. The patients daily, for 6 days in the week, received 100 pounds of fowl. On the seventh day 120 pounds were requisitioned. At this rate there were approximately 37,540 pounds used by the patients during the year. The rest of the fowl purchased, namely, 57,386 pounds, was used by the officers and employees. Since about 350 hospital helpers received almost no fowl, except at holiday seasons, about 675 officers and employees used nearly 20,000 pounds more than the 1,243 patients.

A similar failure to adjust the requisitions to the fluctuating census was noted in connection with several other articles of food used.

Bellevue used 771,075 pounds of meat and fish during the year 1912. This was for both patients and employees. Had the patients been served a half pound per capita per day, which is a greater ratio than that actually used during several months of the year, and had the employees received a pound per capita per day, the total consumption by the Hospital would have been 596,582 pounds. The ratio of 1 pound per day for employees is not only ample, but a heavier meat diet than seems advisable. However, had this ratio been maintained, Bellevue would have saved about $20,900 in meat and fish alone, estimating the cost of the different kinds of meat at an average of 12 cents per pound.

Food Waste

Inasmuch as the amount of meat actually used seemed somewhat excessive, it was deemed advisable to make a detailed examination of the amount of meat used and the method of handling it in several of the kitchens and dining rooms of the hospital. For this purpose the staff dining room, the orderlies' dining room, and the dining rooms in the School for Attendants and in the Nurses' Residence were selected. The employees of these dining rooms were asked to weigh for a period of 1 week the total amount of food returned from, or prepared and not served on, the plates. The amounts reported from these dining rooms are set forth in the following table:

WASTE FOOD IN BELLEVUE HOSPITAL.

Showing the Gross Pounds of Food Served in Dining Rooms and Returned on Plates, upon the Days Indicated, in June, 1912.

Staff Dining Room			Nurses' Residence			School for Attendants			Orderlies' Dining Room		
Weights determined by the Pupil Dietitian			Weights determined by the Housekeeper			Weights determined by the Housekeeper			Weights determined by the Chef		
Average Number served:											
Breakfast.		178			348						
Luncheon.		238			359			80			360
Dinner...		188			348						
Day	Meal	Lbs.	Day	Meal	Lbs.	Day	Meal	Lbs.	Day	Meal	Lbs.
7	B	135	4	B	109	6	B	6	3	B	28
	L	126		L	129		L	11		D	45
Dog meat		3									
	D			D	128		D	25		S	58
9	B	104	5	B	96	7	B	9	4	B	139
Dog meat		36									
	L	128		L	117		L	12		D	65
	D			D	131		D	22		S	78
10	B		6	B	109	8	B	11	5	B	50
	L	114		L	127		L	11		D	79
Bones for dogs		21									
	D	134		D	137		D	12		S	44
11	B	110	9	B	56	9	B	4	6	B	70
Bones for dogs		19									
	L	103		L	73		L	14		D	84
Bones for dogs		32									
	D			D	141		D			S	49
12	B	128	10	B	129	10	B	7	7	B	43
	L	191		L	81		L			D	54
	D			D	123		D	28		S	27
13	B	143	11	B	129	11	B	8	8	B	58
	L	94		L	116		L	9		D	49
Bones for dogs		14									
	D			D	131		D	14		S	42
14	B	141	12	B	133	12	B	6	9	B	46
Bones for dogs		14									
	L	171		L	125		L	7		D	46
Bones for dogs		20									
	D			D	137		D	19		S	50
Total.....		1,981			2,457			235			1,204
Lbs. per day....		269			351			34			172
Per capita lbs. per day.....		1.4			1			.42			.48

It will be noticed in the foregoing table in connection with the staff dining room that 261 pounds of food were returned from the plates on June 7, 1913; 232 pounds were returned on June 9; and 237 pounds on June 13. The total waste food returned from the plates in this dining room during the 7 days amounted to 1,981 pounds.

It will be observed that on most days there was an item named "Dog meat," or, "Bones for dogs." The aggregate amount of this food in the 7 days was 159 pounds. This would feed many more dogs than were found about the grounds of Bellevue.[1]

In the orderlies' dining room the waste food returned from the plates on June 3 amounted to 131 pounds; on June 4, 282 pounds; on June 5, 173 pounds. The total amount of waste food returned from the plates during the 7 days of record amounted to 1,204 pounds.

The waste on plates in the dining room of the School for Attendants on June 6 was 42 pounds, and on June 7 it was 43 pounds. The total amount returned from the plates during the 7 days in which the waste was noted was 235 pounds.

The plate waste in the dining room of the Nurses' Residence on June 4 was 366 pounds, and on June 6 it was 373 pounds. The total plate waste during the 7 days in which the record was kept amounted to 2,457 pounds.

The average per capita waste of food in these dining rooms compared with the same kind of waste in the State Hospital at Kings Park is set forth in the following table:

FOOD WASTE IN BELLEVUE HOSPITAL AS COMPARED WITH SIMILAR WASTE IN KINGS PARK STATE HOSPITAL.

The Figures Represent Only the Waste Food Returned from the Plates.

	Kings Park, July to Dec., 1912.						Bellevue, June 5-12, 1913.				
	A. B. Kitchen	C. D. Kitchen	Group 1	Group 2	Group 3	Total and Average	Orderlies' Dining Room	Staff Dining Room	Nurses' Residence	Mills Training School	Total and Average
Average census per meal..	985	923	1,450	659	394	4,411	360	201	351	80	992
Per capita daily waste—pounds.....	.33	.19	.17	.22	.33	.23	.48	1.4	1.0	.42	.84

According to the above table the lowest per capita waste in Bellevue was in the dining room of the School for Attendants. This was .42 pound per capita, per day, whereas the lowest waste noted in Kings Park State Hospital was .17 pound. The highest per capita waste in Bellevue was in connection with the staff dining room, where it amounted to 1.4 pounds per capita per day, whereas in Kings Park State Hospital the highest per capita daily waste was .33 pound. The average waste in the dining rooms at Bellevue was .84 pound per capita per day, whereas in Kings Park State Hospital it was but .23 pound.

[1] Since this observation was made measures have been taken to regulate and account for meat used as forage.

The marked difference in waste in Bellevue as compared with Kings Park prompted a closer and more detailed investigation in the former. For this purpose the staff dining room and the dining room in the Nurses' Residence were selected. An investigator from the Committee, Mr. Frank E. Brooke, separated the waste from the plates as they came from the dining room during each meal for a period of 6 days. This close segregation of the waste was made for the purpose of determining the chief elements entering into the waste. The dietitians having supervision of each of these dining rooms questioned somewhat the feasibility of making such a separation during the process of serving the meals and washing the dishes, fearing that it would confuse the work and add to the labor of the employees. They, however, consented to allow the investigator to undertake the work, and, when it had progressed but a short time, it became evident that the separation of waste into classes not only did not interfere with the ordinary operations of the dining room and pantry, but added to the facility and speed with which they were carried on. It was conclusively demonstrated that it is practicable to perform such work daily, and in connection with each meal.

According to the separation, recorded in the accompanying tables, the food that was returned on the plates was considered unusable and entered as one class; and the food that remained in the pantry and had not been served on the plates was recorded as another class. In explanation of the table it should be stated that it was assumed that, as the food listed as remaining in the pantry was in a large measure usable, it very likely was served in some form at a subsequent meal, and, therefore, does not enter into the figures of waste.

By comparing the results of the investigator's weighing of waste with that of the employees of the dining rooms, which is shown in the table on page 588, it will be seen that the waste from the plates in the staff dining room amounted to 1,190 pounds during the 6 days in July in which the experiment was carried on, and in a like period of 6 days in June in which the employees weighed the waste it amounted to 1,712 pounds. In the Nurses' Residence dining room the investigator recorded 1,361 pounds, whereas the employees reported 2,106 pounds. The lesser amount of waste noted by the investigator may have been partly due to the fact that the dining rooms had been experimenting on cutting down the waste during the period from June 5 to the latter part of July, when the investigator made his experiment, and it may also be explained by the supposition that the employees, in their experiment, may have included certain elements of non-usable food which were excluded by the investigator. The latter excluded all liquids, but some may have been included in the experiment carried on by the employees.

A detailed examination of the following table will show marked waste of certain articles of food. For instance, on July 19 40 pounds of lamb chops served at lunch were returned from the plates. It is probable that a large percentage of this amount was bone, but the investigator reported verbally that a good proportion of it was composed of chops which had not been touched, or had been only partially eaten. On July 21 25 pounds of porterhouse steak were returned from lunch. This was all edible meat. At the same meal 38 pounds of porterhouse steak remained in the pantry unserved. On July 22 35 pounds of liver and veal cutlets were returned from lunch, and from evening dinner 25 pounds of roast beef and chicken

FOOD WASTE.

STAFF DINING ROOM—BELLEVUE HOSPITAL.

Analysis of Waste and Usable Food Returned from Dining Room to Pantry during 6 Days Ended Friday, July 25, 1913.

			Pounds of Waste Food Returned from Plates.								Pounds of Usable Food Left Over, Not Served to Dining Room.			
Day	Meal	Kind of Meat served	Meat	Bread	Cereals	Salad (Including Lemon Scraps)	Potatoes	Dessert		Plate Scraps Principally Vegetables	Meat and Bone	Potatoes	Other Vegetables	Dessert
July 18	L	Fish and Steak.....	4	1	...	11	8	Pie.....	7	13	15	3	...	...
	D	Fish and Roast Beef.	1	2	...	...	10	Pie.....	8	17	22	12	7	...
July 19	B	Bacon and Eggs.....	8	7	3	...	5	Cantaloup Rinds.....	52	....	...	...	...	...
	L	Lamb Chops.....	40	1	...	15	6	"	76	....	7	3	...	...
	D	Roast Veal and Ham.	6	1	...	9	8	Pie.....	6	1	43 (Ham)	10	12	...
July 21	B	Bacon and Eggs.....	9	6	4	17	2	.....		....	...	...	...	...
	L	Porterhouse Steak...	25	2	...	11	...	Cantaloup Rinds.....	60	11	38	8	...	...
	D	Roast Veal and Roast Mutton.....	6	2	...	9	9	Pie.....	8	3	38	5	...	4
July 22	B	Bacon and Eggs.....	6	8	7	23	3	.....		....	...	...	...	...
	L	Liver and Veal Cutlets	35	2	...	13	3	Watermelon Rinds.....	147	....	...	...	...	...
	D	Roast Beef and Chicken.....	25	1	...	8	7	Pie.....	10	2	40	11	....	...
July 23	B	Bacon and Eggs.....	8	6	...	27	5	.....		....	...	...	...	...
	L	Steak.....	18	1	...	22	8	Pie.....	8	....	46	6	...	...
	D	Roast Beef.....	4	1	...	7	11	Pie.....	9	9	27	11	9	...
July 24	B	Bacon and Eggs.....	8	7	2	15	5	.....		....	...	...	...	...
	L	Hamburg Steak and Ham.....	21	2	...	13	8	Cantaloup Rinds.....	70	....	9	6	...	...
	D	Veal and Corned Beef	7	2	...	9	10	Pie	4	2	26	10	3	...
July 25	B	Bacon and Eggs.....	7	6	3	24	5	.....		....	...	...	...	...
Totals.....			238	58	19	233	113		471	58	311	85	21	4
Total.....										1,190				421

Average daily waste 198
Average daily waste per capita (average daily census 202) ..... .98

were returned. At the same time there remained in the pantry, unserved, 40 pounds of roast beef and chicken. On July 23 18 pounds of steak were returned from lunch, and 46 pounds remained in the pantry unserved.

On July 21 9 pounds of bacon and eggs were returned from breakfast, but this included a small amount of toast. The actual number of eggs wasted was not determined, but, according to the weights, and the proportion of bacon, toast, and eggs reported by the investigator, it is probable that not less than 6 pounds of this total weight consisted of eggs, which would represent not less than 4 dozen eggs. Nearly as high a ratio of waste was noted in connection with each breakfast, which in all cases was composed of bacon and eggs.

It will be noticed that salad was served in connection with most of the meals, and that the waste was large. For instance, on July 22 23 pounds of salad were returned from breakfast, and 13 pounds from lunch. On July 23 27 pounds of salad were returned from the plates at breakfast, and 22 pounds from lunch. The salad served was composed largely of lettuce.

In this waste, however, was included lemon peels, and many unused pieces of lemon. It is the custom to serve lemons for use on salads, in lemonade, and tea. A large percentage of these lemons were returned to the pantry, either unused or but partially used.

It will be noticed in the column headed "Dessert" that cantaloup was served at 4 meals during the 6 days, and also that the waste was heavy. The average waste, which included uneaten portions as well as rinds, amounted to 82 pounds.

In the same class of food the waste of pie was also found to be large. On July 18 7 pounds of pie were returned on the plates; 8 pounds on July 21; and 10 pounds on July 22. This indicates that, on an average, fully 8 pounds of pie were returned from the plates each time it was served.

The average daily waste of food returned from the plates was 198 pounds, or .9 pound per capita per day. As previously stated, the highest per capita waste noted in connection with Kings Park Hospital was .33 pound, and the lowest .17 pound.

The following table sets forth the results of the examination of the waste made by the investigator in the dining room of the Nurses' Residence, in which an average of about 350 people are served at each meal. The examination was made in the same manner as that in the staff dining room.

FOOD WASTE.

DINING ROOM IN NURSES' RESIDENCE—BELLEVUE HOSPITAL.

Analysis of Waste and Usable Food Returned from Dining Room to Pantry during 6 Days Ended August 4, 1913.

			Pounds of Waste Food Returned from Plates					Pounds of Usable Food Left Over, Not Served to Dining Room				
Day	Meal	Kind of Meat Served	Meat	Bread	Cereal	Potatoes	Plate Scraps—Principally Vegetables	Meat and Bone	Potatoes	Other Vegetables	Cereal	Dessert
July 29	B	Boiled Eggs	...	4	20	...	28	...	...	...	...	...
	L	Steak	38	2	...	24	52	8	...	...	...	...
	D	Chicken	51	4	9	25	50	...	...	...	20	...
July 30	B	Boiled Eggs	...	7	38	...	50	...	...	...	...	...
	L	Corned Beef Hash	12	2	...	...	38	21	...	14	...	...
	D	Roast Lamb	19	3	...	21	60	...	...	...	...	...
July 31	B	Boiled Eggs	...	6	30	...	9	...	...	...	...	...
	L	Liver and Bacon	12	3	...	20	32	5	5	...	...	9
	D	Roast Beef	19	3	...	21	34	15	11	6	...	...
Aug. 1	B	Boiled Eggs	...	6	27	...	36	...	...	...	...	...
	L	Fish	12	...	...	7	22	26	...	...	...	...
	D	Fish	20	3	...	29	48	...	9	...	...	...
Aug. 2	B	Boiled Eggs	...	6	26	...	15	...	...	...	...	...
	L	Irish Stew	30	3	...	...	39	...	...	...	...	...
	D	Veal	16	5	...	15	56	13	10	...	...	...
Aug. 4	B	Boiled Eggs	...	6	...	...	28	...	6	...	...	...
	L	Steak	21	3	...	9	34	11	16	...	...	...
	D	Roast Lamb	17	5	...	18	31	...	...	...	...	...
Total			285	71	139	189	677	98	57	20	20	9
Total							1,361					204
Daily waste							231					
Daily waste per capita (average daily census about 350)							.8					

It will be observed by examining the foregoing table, that there was a heavy waste of meat returned from the plates. On July 29 38 pounds of steak were returned from lunch and 51 pounds of chicken from dinner. However, not all of this large amount of chicken waste was returned from the plates, but a portion of it had remained in the pantry, unserved, and while hot was placed in the icebox, with the intention of serving it the following day to the help, but, because of its condition when placed in the icebox, it spoiled.

On August 2 39 pounds of Irish stew were returned from the plates and put into the garbage, and 56 pounds of veal were returned from dinner, while on August 4 28 pounds of steak were returned from the lunch plates.

It will be noticed that there was a heavy waste of cereal. On July 29 20 pounds were returned from breakfast; on July 30 38 pounds; on July 31 30 pounds; on August 1 27 pounds; and on August 2 15 pounds. The total waste of cereal for the 6 days was 139 pounds, or about .4 pound per capita. The total waste of cereal in the staff dining room for 6 days was but 19 pounds, or, .09 pound per capita. The excessive waste of cereal in the Nurses' Residence, as compared with the staff dining room, is probably due to the difference in the method of serving, and the kinds of cereal used. In the staff dining room the cereal is served from the pantry in individual dishes, whereas in the nurses' dining room the cereal is served from a tureen placed on each table. The staff dining room gives a choice of several kinds of cereal, whereas but one kind is served in the nurses' dining room.

It will be observed that under the head of "Plate scraps" there was a total of 677 pounds of waste during the 6 days. These scraps were composed of various articles of food that were mixed together on the plates, and could not be readily separated. At breakfast, for instance, the eggs were served in the shell, and not infrequently when unused were broken and mixed into various foods upon the plates. A salad at lunch was served, and when it was returned to the pantry it had been mixed with other waste food on the plates. The chief element of waste at dinner was vegetables; at lunch it was vegetables and salad.

The daily waste of all food served in this dining room during these 6 days amounted to 281 pounds, and the daily per capita waste was .8 pound.

It is notable that the amount of food left in the pantry not served on the plates amounted to 204 pounds in the nurses' dining room, and 421 pounds in the staff dining room. It is evident that the nurses' dining room adjusts the amount of food much more closely to the needs of the persons served than does the staff dining room.

During the week ended July 22 the staff dining room requisitioned and received 2,576 pounds of meat, which provided for 1.8 pounds per capita per day. The nurses' dining room requisitioned and received during the week ended August 3 3,076 pounds of meat, which provided 1.26 pounds per capita per day. Such per capita portions are much larger than the portions provided in most private families.

The use of such an excessive amount of meat was doubtless due, in a measure, to the method of serving. In the staff dining room each individual was served with a piece of steak from 4 to 5 inches in diameter and more than an inch in thickness, and hamburger steak was made in patties fully 4 inches in diameter and more than an inch thick. These large individual portions were served on the plates in the pantry, and, as a result

of such over-generous service, much meat was returned uneaten, and, in many cases, more was eaten than is probably conducive to health.

Because of this method of serving meat the Dietitian was requested, through the Superintendent of the Hospital, to serve meat in much smaller portions, and, so far as possible, to place a platter of meat upon each table and allow a second helping when desired. An experiment in this method of serving was instituted in two dining rooms the last week in August.

Much to the credit of the dietary department this experiment was carried out thoroughly and in good faith. The Committee checked the results of the work for the week ended October 13, 1913, and compared it with the corresponding week of 1912. During the week ended October 12, 1912, Bellevue and its allied hospitals consumed of meat and fish 20,597 pounds. During the week ended October 13, 1913, the consumption was 17,300 pounds, a saving of 3,297 pounds. The census for the week in 1913 was nearly 200 higher than for the week in 1912. Thus, a larger number of patients was fed with 17,300 pounds in 1913 than with 20,597 pounds in 1912. This amount of saving for 1 week represents an estimated aggregate saving for a year of 171,444 pounds, the value of which, at 12 cents a pound, would be $20,573.

The experiment, up to the time of publishing the Report, had not been extended to articles of food other than meat, but it is fair to assume that when the full waste system suggested in this Report is put into operation the aggregate saving on food in the Department of Bellevue and Allied Hospitals will probably be not less than $30,000 annually.

Department of Public Charities

Food Accounting

The General Storehouse on Blackwell's Island is used as a distributing point for supplies to institutions located in Manhattan and the Bronx. Institutions draw on this Storehouse for perishable foods, produce, etc., weekly, and all other supplies monthly. The one-story buildings used as the General Storehouse on Blackwell's Island were built in the sixties, and are now too small. Crockery and chinaware are kept in a separate building on the east side of the Island.

The present system of accounting in operation at the General Storehouse is cumbersome, and involves needless repetitions of entries. Three ledgers are kept: one for food supplies; one for all other supplies; and one for contracts. A ledger for contracts is also kept at 26th Street. The articles are shown both in quantity and amount; and all supplies are billed to the institutions, both in quantity and amount; and the institutions, in turn, enter them on their books in like manner.

The showing of all items in dollars and cents on a storekeeper's records is superfluous, as the Central Office keeps records that contain this information.

The distribution of supplies for Brooklyn and Queens is made in a different manner from that in use in Manhattan and The Bronx.

For the former division there is but one storehouse, from which all supplies are issued daily to Kings County Hospital and the Home for the Aged and Infirm, and three times a week to the other three institutions in Brooklyn, viz.: Reception Hospital, at Coney Island; Cumberland Street Hospital; and Bradford Street Hospital.

The records of supplies, as well as payrolls, for all institutions are kept at this storehouse, and, so far as can be judged from the consumption of supplies, the centralization of control as adopted in Brooklyn and Queens has resulted in greater efficiency and economy than in the other two divisions.

Special attention was given to the method of accounting for meat supplied.

Meat is sent direct from 26th Street to the institutions on Blackwell's and Randall's Islands, and does not pass through the General Storehouse. An examination was made of the accounting for such meat at Metropolitan and City Hospitals. The total amount of meat sent to these Hospitals was noted from the General Storehouse books, and the amount ordered by the Dietitians to be delivered by the butcher to the kitchens was compiled from the daily order slips of the Dietitians. According to the General Storehouse records, Metropolitan Hospital received during the fiscal year which began January 1, 1911, 431,000 pounds of beef. The Dietitian's records showed that 311,000 pounds were requisitioned from the butcher, and presumably were delivered to the kitchens. This difference in the gross amount received by the institutions and the net amount delivered to the kitchens, 120,000 pounds, was a shrinkage or waste of 27 per cent. It was stated by the Dietitians that not infrequently the butcher would deliver beef to the kitchens on a requisition for mutton or veal, and possibly a portion of this shrinkage or waste was accounted for by that fact. No record, however, was kept of such substitution, and it was impossible to determine to what extent it had taken place.

In Brooklyn the storehouse at Kings County Hospital receives and distributes the meat for Kings County Hospital, the Home for the Aged and Infirm, Coney Island Hospital, Cumberland Street Hospital, and Bradford Street Hospital. As heretofore stated, delivery is made daily to Kings County Hospital and to the Home, and tri-weekly to the other institutions. The butcher delivers to the institutions on requisitions from the Dietitians, and, in the case of Kings County Hospital, the actual weights received are checked against such requisitions by the Dietitian's assistant. In this storehouse the butcher keeps a record of the amount of meat distributed, which record was checked by your examiners against the records of the meat actually received by the Dietitian. As an illustration of the extent to which these two records disagree, the deliveries for the first week in January, 1912, show the following discrepancies:

According to the records of the Dietitian, Kings County Hospital received 2,452 pounds of beef, and 970 pounds of bone and stock, making a total of 3,422 pounds. The butcher charged the Hospital with 1,739 pounds of fores and 2,312 pounds of hinds, or a total of 4,051 pounds, which made a difference in the records of 629 pounds, or a variation of 15.5 per cent. The butcher, at the same time, was delivering beef to the Home for the Aged and Infirm, without keeping an account of such deliveries. Whether or not, through error, he charged Kings County Hospital with some meat delivered to the Home, it was impossible to determine.

To ascertain what should be the normal, or usual, amount of shrinkage and waste between the gross amount received by the butcher and the net amount delivered to the kitchens, inquiry was sent to several of the New York State Hospitals for the purpose of learning what had occurred in those institutions with regard to this matter. To such inquiries the following replies were received:

Manhattan State Hospital, Ward's Island, Sept. 24, 1912.

The loss between the gross weight of beef received by the butcher and the net amount distributed to the kitchen is approximately 2 per cent., which is accounted for by the suet fat being cut off, the chips from bones, and the loss from cutting, etc.

Central Islip State Hospital, Oct. 1, 1912.

The difference between the gross weight of beef received by our butcher and net amounts distributed to the kitchens is an average of about 1 per cent. in waste and shrinkage.

Hudson River State Hospital, Poughkeepsie, Oct. 18, 1912.

The shrinkage in beef at this hospital is practically nil. This is accounted for by the fact that we are fortunate in having our present deliveries made two or three times weekly from local coolers in the city. In this way, the meat is in our coolers but a short time before it is cut up and issued.

It will be observed from the above letters that no institution reported a shrinkage of more than 2 per cent. This shrinkage in the State institutions evidently consisted of the natural evaporation of the meat due to storage, and also the scrap waste due to cutting the meat; and inasmuch as practically all bone and fat should be sent to the kitchens as partly edible, these percentages given should cover any and all loss shown by the records.

By experiments carried on at Rochester State Hospital it has been determined that the total bone of the average carcass is approximately 19 per cent. of the total weight of the carcass. By careful records kept during the month of October, 1912, at Hudson River State Hospital it was found that the butcher sent to the kitchens in the form of bone-cuttings and fat about 15 per cent. of the total weight of meat received by him. Kings Park State Hospital reported that their records of distribution from October 1, 1911, to April 15, 1912, showed that about 8 per cent. of the gross weight of beef received by the institution was delivered by the butcher to the kitchens in the form of bone-cuttings and fat. The total unaccounted-for shrinkage at Kings Park was less than 1.5 per cent.

It seems clear that the institutions of the Department of Charities under consideration are not exercising due care, either in their system of handling meat, or in their methods of accounting for it.

Food Consumption

It was impossible to examine the handling of food in the Department of Public Charities to the extent that it was examined in the Department of Bellevue, owing to lack of time, and it was assumed that, if the per capita amounts of food used in the Department of Charities showed a marked variation in the different institutions, the detailed method of inquiry used in Bellevue could be subsequently applied by the Commissioner of Charities to the hospitals in his Department. Accordingly, the only examination made in the Department of Charities was an examination of the total amounts of food used month by month during the year 1911 in the different institutions. The results of this examination are set forth in tables on pages 616 to 626.

By referring to these tables, it will be observed that there is a marked difference in the per capita consumption of the same articles in different institutions having population of like character. For instance, of flour and wheat products, Kings County Hospital used 175.78 pounds per capita per year, as compared with 290.95 in City Hospital. Metropolitan Hospital used 280.20 pounds of the same articles of food. This marked difference in the amount of wheat products is not compensated for by a greater

use of some other articles having similar food values. Though Kings County Hospital used a much smaller quantity of wheat products than City or Metropolitan Hospital, yet its consumption of beef and veal was almost proportionately smaller, having been 174.40 pounds per capita per year, as compared with 190.65 pounds in City Hospital, and 191.25 pounds in Metropolitan Hospital. Its consumption of other meats was in about the same proportion as in the other two hospitals.

The total amount of food used in Kings County Hospital was 1,376.47 pounds per capita per year, as compared with 1,649.39 in City Hospital, and 1,722.51 in Metropolitan Hospital. A portion of this larger per capita consumption in Metropolitan Hospital may be legitimately accounted for by the necessity of using eggs and milk more freely as a diet for tuberculous patients. Whereas, Kings County Hospital used 507 pounds of milk per capita per year, and City Hospital 588 pounds, Metropolitan Hospital used 741 pounds. Likewise, with regard to eggs, Kings County Hospital used 48 pounds per capita per year, and City Hospital 54 pounds, Metropolitan Hospital used 86 pounds.

A still more marked contrast may be noticed in comparing Cumberland Street Hospital with the two hospitals on Blackwell's Island. Cumberland Street Hospital used 1,340.88 pounds of food per capita per year, as compared with 1,649.39 pounds in City Hospital, and 1,722.51 pounds in Metropolitan Hospital. The chief items of food of which there was less consumed in Cumberland Street Hospital were wheat products, beef and veal, eggs and milk. It is also interesting to observe that the use of food per capita in Coney Island Hospital was 1,628.10 pounds per capita per year, as contrasted with 1,340.88 in Cumberland Street Hospital. The largest use of food was noted in Bradford Street Hospital, where it amounted to 2,042.36 pounds per capita per year. The excessive amount can be partially explained by the fact that it was largely served to officers and employees, there being an average of about one patient per day. This fact, however, is hardly sufficient to explain the issue of 5.59 pounds of food per capita per day, which includes an average of 5 eggs per capita per day. The consumption of coffee is also of interest, having been 33 pounds per capita per year, as contrasted with 15 pounds in Coney Island, and 11 pounds in Cumberland Street, Kings County, City, and Metropolitan Hospitals.

The amount of protein in the food supplied makes quite as interesting a comparison. In Kings County Hospital the food contained 108.79 grams of protein per day, as compared with 138.70 grams per day in City Hospital, and 143.74 grams per day in Metropolitan Hospital. On the other hand, in Cumberland Street Hospital the food contained but 100.61 grams per day per capita, while in Bradford Street it contained 162.63 grams. A like difference was found in the calories in the food. The food used in Kings County Hospital contained 3,021 calories per capita per day, as compared with 3,820 in City Hospital, and 3,795 in Metropolitan Hospital. In Coney Island Hospital the food contained about the same number of calories, whereas in Bradford Street Hospital it contained 5,100 calories.

Though Kings County Hospital seems to have been much more economical than the hospitals in Manhattan in the amount of food used, it was not more economical in the purchase of that food. The average cost per pound of the food under consideration was 5.25 cents in Kings County Hospital as compared with 5 cents per pound in City Hospital, and 4.8 cents per pound in Metropolitan Hospital.

A like contrast was noted between the amounts of food used in the Homes for the Aged and Infirm. The Brooklyn Home used 916.87 pounds of food per capita per year, as contrasted with 1,113.89 pounds used by the Manhattan Home. In other words, the Manhattan Home used over 21 per cent. more food than the Brooklyn Home. This is not only true as to the total number of pounds used, but also true as to the protein and calory elements. In the Brooklyn Home the food contained 85.79 grams of protein per capita per day, as compared with 104.96 grams in the Manhattan Home; and in the former the food contained 2,640 calories per capita per day, as compared with 3,301 in the Manhattan Home. Here, again, although there was a marked saving in the Brooklyn Home in the amount of food used as compared with the Manhattan Home, its cost per pound was greater; viz., 5 cents per pound in the Brooklyn Home, as compared with 4.5 cents per pound in the Manhattan Home. The record for Farm Colony shows that both the amount of food used and its cost was very nearly the same as in the Manhattan Home.

A detailed examination of the amount of beef used in Metropolitan Hospital and City Hospital shows that the issue per capita was somewhat heavier in the 6 warmer months of the year than in the 6 colder months. In City Hospital the average daily per capita issue for the months of January, February, and March, 1911, was .49 pound; for April, May, and June the same amount; for July, August, and September .48 pound; and for October, November, and December .47 pound. In Metropolitan Hospital the average daily per capita consumption for January, February, and March, 1911, was .53 pound; for April, May, and June .56 pound; for July, August, and September .54 pound; and for October, November, and December .50 pound. It is remarkable that more beef was supplied to the inmates during the time when fresh vegetables were abundant than in the colder winter months, when vegetables were accessible only in dried or canned form.

It is interesting to compare the amount of food used by the hospitals of the Department of Charities with the amount used by the New York State hospitals for the insane. The average per capita issue of food, with the exception of green vegetables and cooking accessories, in Binghamton, Rochester, Kings Park, Middletown, and Utica State Hospitals during the year ended September 30, 1910, was 1,236.57 pounds. The average issue in the hospitals in the Department of Public Charities, for the year beginning January 1, 1911, was 1,605.66 pounds. It will be observed that the average per capita issue in these acute and semi-chronic hospitals was 369.09 pounds in excess of that used in the insane hospitals. Inasmuch as a smaller proportion of the inmates in insane hospitals are bed patients than in acute hospitals, it is highly probable that the amount of nutriment required by the patients in insane hospitals should be somewhat greater than for patients in acute and semi-chronic hospitals.

This difference noted in the per capita amounts of the totals of food used was also noted in connection with the consumption of meat. The five State hospitals above referred to supplied their patients, on an average, 204 pounds of meat per capita per year, whereas the hospitals in the Department of Charities supplied, on an average, 266.86 pounds per capita per year. If this latter amount be subdivided according to the hospitals in Manhattan and The Bronx, and those in Brooklyn, the average amount used in the Manhattan and Bronx institutions will be found to be 271.51, and in Brooklyn, 256.35 pounds per capita. The Manhattan institutions

used about 67 pounds per capita more than did the State institutions, an excess of 32 per cent. It seems improbable that the patients in our acute hospitals should require more of this heavy diet of meat than is required by the more rugged inmates of the insane hospitals.

Though the amount of food consumed in the Children's Hospitals and Schools on Randall's Island was, per capita per year, about the same as in Kings County Hospital, namely, 1,315 pounds in the schools, as compared with 1,376 pounds in Kings County Hospital, nevertheless, there seems not to have been a larger proportion of milk and eggs served to the children than was used in Kings County Hospital. In the Children's Hospitals 522 pounds of milk per capita per year were used, as compared with 507.61 pounds in Kings County Hospital. The Children's Hospitals used but 25.26 pounds of eggs per capita, as compared with 48.63 pounds used by Kings County Hospital.

In considering the amount of food necessary for use in the hospitals it is interesting to note the fact that the Municipal Lodging House supplied but 1,066 pounds of food per capita per year, as contrasted with 2,042 pounds used by Bradford Street Hospital; 1,628 by Coney Island Hospital; 1,340 by Cumberland Street Hospital; 1,376 by Kings County Hospital; 1,649 by City Hospital; and 1,722 by Metropolitan Hospital. The food in the Lodging House contained but 93 grams of protein per capita per day, as contrasted with an average of 131 grams in the above named institutions. Some inquiry has been made to ascertain, if possible, whether the amount of food furnished in the Municipal Lodging House seemed to be sufficient. So far as it was possible to learn enough food is furnished, though complaint is made as to the manner in which it is cooked and served.

Food Budget

It has been the custom of the Department of Public Charities in estimating its budget for food to take the total amount expended for food for all of the institutions in Manhattan, Richmond, and The Bronx, and separately the institutions in Brooklyn, and to add thereto a percentage for an anticipated increase in population. No effort has been made to ascertain whether or not the money expended for food has been expended for the various kinds of food in proper proportion, or whether or not certain of the institutions were using more of certain kinds of food than they should, or whether or not there had been waste in certain institutions that should have been cut down by allowing a less amount for the succeeding year.

Because of this rather unscientific and haphazard method of determining the amount of money needed for food for the ensuing year, it has been deemed advisable to submit, for consideration, a schedule on which to base an estimate of the amount of food needed in the hospitals, and also in the almshouses of the Department. A suggested schedule, as applied to the general hospitals, has been set forth in table form on page 608. The table provides for 1,500 pounds of food per capita per year. Kings County Hospital used 1,376 pounds per capita during the year 1911, and Cumberland Street Hospital 1,340 pounds, whereas Coney Island Hospital used 1,628 pounds; City Hospital 1,649 pounds; and Metropolitan Hospital 1,722 pounds. Inasmuch as Kings County Hospital apparently served its patients and employees an adequate amount of food, it may be assumed that City Hospital and Coney Island Hospital either served too much or

wasted food. According to the table Metropolitan Hospital would be allowed 845 pounds of food additional for each of the tuberculous patients, which would make an average of 1,900 pounds per capita for all patients and employees in the institution.

A schedule is submitted on page 609 as a basis for estimating the number of pounds of the various kinds of food needed for the almshouses. This table provides for 1,138 pounds of food per capita per year, which is a larger amount than was used during 1911 by either of the City Homes. The Brooklyn Home used but 917 pounds, and the Manhattan Home but 1,114 pounds per capita per year. The chief items of increase are butter, mutton, ham, shoulder, fresh fish, salt fish, canned fruits, and vegetables. In the Brooklyn Home the food contained but 85.79 grams of protein per capita per day, and 2,640 calories. The schedule submitted provides for 102.17 grams of protein and 3,195 calories per capita per day. This would increase the food elements for the Brooklyn Home, and give about the same amount supplied in the Manhattan Home; and would also give a more acceptable variety of food. It is believed that the proportions and amounts of food suggested in the schedule will make a more acceptable diet for the inmates and provide better feeding.

Department of Health

Food Consumption

It was not possible to make a detailed examination of the method of handling food in the institutions in the Department of Health because of lack of time. The books of the institutions in that Department were examined to determine the total amounts of the different kinds of food used in the institutions during the year 1912. The results of this examination will be found in tables on pages 627 to 630.

Upon examination of these tables it will be observed that there was considerable difference between the amounts of food consumed in the different hospitals of the Department dealing with approximately the same class of patients. Willard Parker and Kingston Avenue Hospitals had, in the main, the same class of patients. Willard Parker Hospital supplied 1,655 pounds of food per capita per year, as compared with 1,371 pounds in Kingston Avenue Hospital. The amount provided in Willard Parker Hospital contained 116 grams of protein and 3,205 calories per capita per day, and that supplied in Kingston Avenue Hospital contained 87 grams of protein and 2,578 calories per capita per day. The details of these quantities are of special interest. Willard Parker Hospital used much more meat than did Kingston Avenue Hospital, the comparison being 300 pounds per capita per year in Willard Parker Hospital, as compared with 164 pounds in Kingston Avenue Hospital. Willard Parker Hospital also used considerably more milk, flour, and wheat products. On the other hand, Kingston Avenue Hospital used 35 pounds of eggs per capita per year, as compared with 22 pounds in Willard Parker Hospital. Kingston Avenue Hospital used 50 pounds of sugar per capita per year, as compared with 41 pounds in Willard Parker Hospital.

The Sanatorium at Otisville, which is devoted exclusively to the care of tuberculous patients, used more food per capita than did Riverside Hospital, which, though caring for a large proportion of tuberculous patients, has a certain number of cases of mixed contagion. Otisville Sanatorium used 2,447 pounds of food per capita per year, as compared with 2,207 pounds

in Riverside Hospital. The chief element of difference between Riverside Hospital and Otisville Sanatorium was in flour and wheat products, potatoes, canned vegetables, and eggs. Otisville Sanatorium used considerably less of each of these articles, but more of milk and meat, than Riverside Hospital.

Both of these institutions used a much larger quantity of meat than any of the other hospitals. Otisville Sanatorium used 573 pounds of meat per capita per year, and Riverside Hospital used 464 pounds. This large use of meat prompted an inquiry to determine what proportion of meat other tuberculosis sanitaria were using. The number of pounds of meat per capita per year used by the tuberculosis hospitals from which reply was received are shown below:

Samuel W. Bowen Memorial Hospital, Poughkeepsie, N. Y.	227	Pounds
Boston Consumptives' Hospital, Mattapan, Boston, Mass.	228	"
New York State Sanatorium for Incipient Tuberculosis, Raybrook, N. Y.	296	"
Metropolitan Hospital, New York City, N. Y.	299	"
Adirondack Cottage, Trudeau, N. Y.	410	"

It will be noticed that the only tuberculosis hospital using an amount of meat similar to that used in most of the municipal hospitals of New York City was the sanatorium at Lake Saranac (Adirondack Cottage), formerly supervised by Dr. E. L. Trudeau. Under date of August 5, 1913, Dr. Trudeau, in a letter to the Director of this investigation, said:

> * * * we have never worked out the per capita pounds of meat consumed, * * * We make no special effort to feed patients meat, but we encourage it and they seem to crave it, and, if not carried too far, a meat diet has seemed to me a favorable factor in helping to arrest the disease. As I said before, we have made no special effort to give as much meat as possible, nor do I think this would be advisable. I think no doubt the meat portion could be reduced somewhat, and flour or cereals substituted without any serious risk.

The amount of meat which it is most advisable to serve to tuberculous patients seems not to have been closely determined. Inasmuch, however, as the sanatorium at Saranac Lake has had marked experience and success in the treatment of incipient tuberculosis, its method of treatment and feeding is of value in determining the amount which should be served by our municipal institutions. It will be noticed that the amounts served at Otisville (573 pounds per capita per year) and Riverside Hospital (464 pounds per capita per year) are considerably in excess of that at the Saranac Lake sanatorium; and, moreover, in Riverside Hospital many of the patients are not tuberculous.

It is suggested that the schedule for estimating the amount of food needed per year for general hospitals could be applied to the institutions at Otisville and Riverside. In applying it to these institutions, however, the amount of food required for the employees and non-tuberculous patients would be figured at 1,500 pounds per capita per year, and for tuberculous patients the amount would be 2,345 pounds per capita per year.

General

Institutions have given too little attention to the gross amount of food necessary to furnish an ample and healthful diet. The per capita yearly consumption, as found by your Director, in the State institutions caring for a like class of patients varied: in insane hospitals, from 1,089 to 1,481 pounds; in soldiers' homes, from 1,232 to 1,723 pounds; in industrial

schools, from 1,133 to 1,600 pounds; in reformatories, from 948 to 1,209 pounds; and in prisons, from 1,149 to 1,740 pounds. There would naturally be a variation in the total number of pounds furnished to patients or inmates in different institutions, according to the proportion of different classes of food used, but the quantities of food indicated above varied in the amount of protein per capita per day from 89.64 to 122.43 grams, and in calories from 2,962 to 4,157. This wide variation in the amounts and varieties of food provided in different institutions caring for the same class of inmates indicates a lack of adequate consideration on the part of the officers in control of the important problem of the varieties and quantities of food necessary for satisfactory feeding.

The municipal institutions in New York City apparently have given this question little study, inasmuch as the total quantities and the proportions of different kinds of foods varied markedly in institutions harboring the same class of patients or inmates. It has been determined, with a reasonable degree of certitude, that active, vigorous males performing reasonably heavy labor throughout the day do not require more than 120 grams of protein and 3,600 calories per capita per day. Some very trustworthy authorities place the requirements much lower than this amount. Patients in hospitals and inmates in almshouses probably require considerably less than this amount. The satisfactory feeding of insane patients, who are relatively able-bodied, on 100 grams of protein and 3,000 calories per capita per day would seem to indicate that general hospitals, with a large proportion of sick patients, and almshouses, whose inmates mostly are infirm, would not require a greater amount of food than the average amount used in insane hospitals.

As previously shown, in the Department of Bellevue, Gouverneur Hospital provided for its patients and employees an average of 119.8 grams of protein and 2,959 calories per capita per day, whereas Harlem Hospital provided 126.8 grams of protein and 3,373 calories. Bellevue Hospital itself provided 122.3 grams of protein and 3,240 calories per capita per day.

In the Department of Public Charities, Cumberland Street Hospital provided 100.6 grams of protein and 3,038 calories per capita per day, whereas City Hospital provided 138.7 grams of protein and 3,820 calories, and Metropolitan Hospital 143.7 grams of protein and 3,795 calories per capita per day.

In the Department of Health, Kingston Avenue Hospital provided 87.26 grams of protein and 2,578 calories per capita per day, whereas Willard Parker Hospital provided 116.48 grams of protein and 3,205 calories. The two hospitals caring for tuberculous patients provided somewhat larger amounts, but the amounts differed. Riverside Hospital provided 165.5 grams of protein and 4,484 calories, whereas the Sanatorium at Otisville provided 137.9 grams of protein and 3,699 calories per capita per day.

These figures show marked irregularity in the amounts of food served to patients of like character in the same department, and the amounts served to patients of like character in the different departments. It seems highly desirable that a recognized standard of feeding be adopted, taking into consideration the different classes of patients to be fed. It is the opinion of your Director that for patients in general hospitals the proportions need not exceed 100 grams of protein and 3,000 calories per capita per day; for tuberculous patients, 130 grams of protein and 3,500 calories per capita per day; for inmates of almshouses, 90 grams of protein and 2,800 calories

per capita per day; and for employees, 115 grams of protein and 3,500 calories per capita per day.

Superintendents of hospitals, or heads of departments operating hospitals, have been somewhat handicapped in their endeavor to regulate the kinds, proportions, and total amounts of food furnished to the patients and employees. This has been due in a measure to the form of records used. Practically all institutions keep their accounts of food purchased and distributed in terms of dollars and cents, and when periodical reports are made to the head of the hospital or department a summary is prepared in like terms. It is very difficult for the officer in control of the hospital or department to quickly determine the relative amount of food that is being used when such food is reported in terms of money only, chiefly because the market prices vary from time to time, and the specifications for food may be different in different periods. In order to get an accurate idea of what has actually been used it becomes necessary to translate the cost figures into quantity figures, which translation is very seldom made. A superintendent can get a clear idea of the proportions of food used only when such proportions are stated in quantity figures rather than cost. On an average a given number of patients or employees will consume a definite amount of food, the amount for the patients being different from that required by the employees. In order to regulate these proportions the superintendent should have before him monthly a statement of the amounts of different kinds of food that have been served during the previous month, with such amounts translated into terms of protein and calories. He should also know the gross amount of food used during the month, and the proportion it bears to the estimated amount for the year. With such a statement in hand he should be able to readily determine whether or not his patients are being served an adequate amount and sufficient variety to constitute a satisfactory diet. He will also know whether or not the proportions of food being used exceed the proportions allotted by the budget for the year.

For the purpose of placing the above-indicated information before the superintendent of an institution, or the head of a department controlling an institution, it is suggested that a form similar to that accompanying this Report, opposite page 610, be adopted.

Basic Dietary Tables and Waste Accounting System in Kings Park State Hospital

In the fall of 1910 the steward of Kings Park State Hospital, at Kings Park, Long Island, installed a system of separating and recording waste from the dining room and pantries, and, in combination with this system, devised a basic dietary table. The results of its operation for nearly three years were so marked that it seems advisable to describe it in some detail, with a view to securing its adoption in our municipal hospitals.

The basic dietary table is designed to indicate the number of pounds to be issued of any article of diet for a given number of patients or employees. The following will indicate the general method of constructing this table:

Number of Eaters.		150	160	170	180	190	200	210	220
	Ounces per Capita	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.
Roast Beef.....	9	84	90	95½	101	106½	112	117½	123
Potatoes (peeled).	8	75	80	85	90	95	100	105	110

The quantity of each variety of food has been estimated for a certain number and increased by successive additions of ten "eaters." When the dining room census exceeds 300 the rate of increase is 20 instead of 10. Such a table enables the steward or person making out a requisition to see at once the number of pounds that should be entered on the requisition for the number of patients in his department. It requires no estimating or figuring. In using the table the ratio next lower or higher than the actual census of the dining room is used, according to the amount of waste that has been reported for the previous issue of the food under consideration. For instance, if the dining room census showed 97, and potatoes were to be issued, and according to the waste account for the previous issue the waste had been excessive, the next requisition would be based upon the amount for 90 people. Had the waste been below normal the issue would be upon the basis of 100 people. Thus, it becomes easy to increase or decrease the per capita amount served to each kitchen; such increase or decrease to be governed by the amount of waste previously reported.

The waste accounting system requires the person in charge of the pantry to keep together all food returned with the plates as one class, and the food not served on the plates as another class; and each of these classes is separated into food articles, so that the steward may readily know whether or not any particular article of food is being served in proper proportions, or is acceptable to the patients. For instance, the steward of Kings Park State Hospital noticed that one dining room was returning much more bread from the table than another, each of which dining rooms was receiving the same per capita proportion of bread. Upon inquiry it was discovered that in the kitchen serving the dining room which had returned the larger amount of bread the employees had cut the bread several hours previous to the meal, and as it had dried off on the surface and was not palatable a smaller proportion of it was eaten than in the dining room where it was freshly cut. This was detected by means of the waste accounting system, and probably would not otherwise have been discovered.

During the 6 months from July 1 to December 31, 1911, AB Kitchen returned as waste food from the plates 75,372 pounds, and CD Kitchen returned 48,103 pounds. During the same period, in 1912, AB Kitchen returned 59,839, and CD Kitchen 32,634 pounds. Thus, in these two kitchens alone the institution apparently saved by the operation of the waste system during a period of 6 months about 31,002 pounds of usable food, which amount was probably wasted before the installation of the waste accounting system.

No difficulty has been found in operating the system; it does not interfere with other functions of the kitchen, pantry, or dining room; it gauges accurately the amount of food needed for the patients and the kind that they will readily consume; it makes all the employees connected with the serving of food much more careful, inasmuch as it is possible for the

GRADUATED RATION DIPPERS
(A TINSMITH CAN MAKE THE DIPPERS AND THE LADLES CAN BE PURCHASED AT THE STORE OF ANY KITCHEN OUTFITTER)
SMALL, GRADUATED, RATION DIPPER FOR USE IN KITCHENS FOR MEASURING COOKED CEREALS—— (OATMEAL, CORNMEAL, CORN STARCH, WHEAT FLAKES, MOLINY, FARINA, RICE, ETC.) BAKED OR BOILED BEANS, ETC.
CAPACITY A 1/2 QUARTS—SIZE 8" x 8 3/4" INSIDE MEASUREMENTS.
FOR 20 RATIONS—EACH GRADUATION REPRESENTS 5 RATIONS.
THE FOOD IS MEASURED INTO FOOD BOXES WITH THE RATION DIPPER AND THEN SENT TO THE DINING-ROOMS
EXTRA HEAVY LADLE #10—CAPACITY 1 1/2 GILLS FOR USE IN DINING-ROOMS.
ONE LADLE FULL REPRESENTS A RATION FOR ONE PERSON.
FOR SERVING CEREALS, BEANS, ETC., DESCRIBED ABOVE AND DESSERTS OF DIFFERENT KINDS—— (PUDDINGS, STEWED FRUIT, ETC.) TO MEN SEWARDS AND EMPLOYEES.
LARGE, GRADUATED, RATION DIPPER FOR USE IN KITCHENS FOR MEASURING SOUPS, OYSTER STEW, CHOWDERS, MEAT STEW, TEA, COFFEE, ETC.
CAPACITY 6 1/2 QUARTS—SIZE 6 3/4" x 9 3/4" INSIDE MEASUREMENTS.
FOR 20 RATIONS—EACH GRADUATION REPRESENTS 5 RATIONS
THE ARTICLES ARE MEASURED INTO CANS OR FOOD BOXES WITH THE RATION DIPPER AND THEN SENT TO THE DINING-ROOMS.
EXTRA HEAVY LADLE #12—CAPACITY 2 1/2 GILLS FOR USE IN DINING-ROOMS.
ONE LADLE FULL REPRESENTS A RATION FOR ONE PERSON.
FOR SERVING SOUPS, OYSTER STEW, CHOWDERS, MEAT STEW, ETC.

steward at all times to ascertain with accuracy exactly what is occurring in connection with the handling of food.

Because of the success of the system as operated in Kings Park State Hospital, it seems advisable to suggest that a similar system be installed in New York City municipal hospitals, especially in connection with the dining rooms serving employees, in which dining rooms the larger proportion of the food in the institutions is consumed. It probably will not be feasible to adapt the system to the feeding of patients in wards without some modification. Though the system is not so readily adaptable to ward service, yet the amount and character of the waste coming from the wards should be determined as a gauge to the service needed in those wards.

Suggestions for the Reduction of Waste

It seems advisable for municipal hospitals to employ such help as may be necessary to separate and weigh the waste coming from the dining rooms, and remaining in the pantries. To insure greater accuracy in the issuing of food to the dining rooms it seems advisable to provide the kitchens with large, graduated dippers, similar to the one shown in the illustration on the opposite page. The large dipper is designed to be used in connection with soups, stews, tea, coffee, etc., and will hold 20 rations; 5 rations for each corrugation. The large ladle shown has a capacity of one ration of any of the varieties of food served in the large dipper. The small dipper is designed to be used for cereals, and the small ladle has a capacity of one ration. By the use of such dippers and ladles a chef can accurately gauge the amount of each article of food sent to a table or dining room, and if the one-ration ladles be used in the dining room, the amount sent from a kitchen should correspond exactly to the services from these ladles. Where new steam kettles and boilers are to be installed in kitchens it is advisable to have them graduated similarly to these large dippers, so that the chef may know the exact number of rations contained in each kettle. With such equipment it is possible to accurately control the amount of food prepared and served to a dining room, and any excess waste, as observed by the person segregating the waste coming from the dining room, can be regulated in future service by these accurate measures. Such dippers and ladles are in daily use in Kings Park State Hospital and have proven to be very serviceable.

As a suggested basis for issuing foods in our municipal hospitals the table on page 606 is offered. This table indicates the ratio of each kind of food per person; and the total amount to be issued to a dining room, on the basis of the number served in the dining room. The table as presented is only to illustrate the method of constructing a table for the use of any one institution, and a table so constructed should provide for the number of persons in each dining room of an institution. In dining rooms serving less than 300 the table may be constructed upon the basis of units of 10; for instance, the amount figured for 60, 70, 80, 90, 100, etc. For dining rooms serving more than 300, 20 may be used as the unit of increase, and the quantity figured to be served to 300, 320, 340, 360, etc. The tables should be placed in the hands of the dietitian, the storekeeper, and the chef.

The number served at each meal in each dining room should be recorded daily and sent to the dietitian, and upon this count the requisitions for the second day following should be based. The census of patients should likewise be daily sent to the dietitian. This will require a daily

Basic Dietary Allowance Table.

This Table Shows the Basis for the Requisitions for One Meal and the Quantities are Expressed in Pounds, Except as Otherwise Indicated.

	Allowance for Employees				Allowance for Patients			
	Oz. per Capita	60[1] Persons	70 Persons	100 Persons	Oz. per Capita	200[1] Persons	210 Persons	500 Persons
Roast Beef	9	33½	39	56	....	....	....	....
Corned Beef Hash	4	15	17½	25	3	37½	39½	94
Fresh Beef Hash	4	15	17½	25	3	37½	39½	94
Pot Roast (Beef)	9	33½	39	56	5	63	65½	157½
Salmon, Canned	4	15	17½	25	....	....	....	....
Roast Mutton	9	33½	39	56	3	37½	39½	94
Roast Veal	9	33½	39	56	....	....	....	....
Hamburger Steak	6	22½	26	37	....	....	....	....
Beef Stew Meat	6	22½	26	37	3	37½	39	94
Mutton Stew Meat	6	22½	26	37	3	37½	39	94
Fresh Fish	7	26	31	44	5	63	65½	157½
Salt Fish	6	22½	26	37	....	....	....	....
Oysters or Clams	6 ea.	360	420	600	6 ea.	1,200	1,260	3,000
Liver	6	22½	26	37	....	....	....	....
Cold Meat	7	26	30½	44	....	....	....	....
Beefsteak	7	26	30½	44	4	50	52½	125
Chops	8	30	35	50	....	....	....	....
Ham	5	19	22	32	5	63	65½	157½
Fresh Pork	8	30	35	50	4	50	52½	125
Potatoes (peeled)	8	30	35	50	6	63	78	188
Tapioca	4/5	3	3½	5	....	....	....	....
Sago	4/5	3	3½	5	....	....	....	....
Apples, Evap.	1¾	6½	7½	11	1½	16	16½	39
Peaches, Evap.	2	7½	8¾	12½	1½	19	19¾	47
Apricots, Evap.	2	7½	8¾	12½	1½	19	19¾	47
Gelatine	1/5	¾	⅞	1¼	....	....	....	....
Macaroni	1¼	4½	5	8	1	12½	13	31¼
Beans	1½	5½	6½	9½	1½	19	19¾	47
Cheese	1½	5½	6½	9½	1½	19	19¾	47
Green Peas	1	3¾	4¼	6	4/5	7½	8	19
Split Peas	1	3¾	4¼	6	1½	19	19¾	47
Eggs	1 or 2 ea.	....	....	....	1 ea.	200	210	500
Ham with Eggs	5	18¾	22	31	....	....	....	....
Bacon	3	11	13	19	....	....	....	....
Liver with Bacon	4	15	17½	25	....	....	....	....
Corn Meal	7/10	3	3	4½	7/10	8¾	9	22
Hominy	7/10	3	3	4½	7/10	8¾	9	22
Rolled Oats	4/5	3	3½	5	4/5	10	10½	25
Wheatena	4/5	3	3½	5	4/5	10	10½	25
Rice	7/10	3	3	4½	3/5	7½	8	19
Wheat Flakes	4/5	3	3½	5	4/5	10	10½	25
Canned Vegetables,	.03168 gal.	2	2¼	3¼	.03168 gal.	6½	7	17½
Crackers	4/5	3	3½	5	4/5	10	10½	25
Fresh Vegetables	4	15	17½	25	4	50	52½	125
Poultry	10	37½	44	62½	4	50	52½	125

[1] This table should be expanded in ratios of 10 allowances to provide for all dining rooms having a capacity of less than 300. For dining rooms having a capacity of more than 300 the ratio of 20 should be used.

change in requisitions, but it is not difficult to make such a change, owing to the fact that a basic dietary table will indicate at a glance the amount of a given article to be issued. The dietitian, when making out the requisition, should stamp upon it the number of persons to be served by such requisition. The storekeeper and chef, having in hand a statement of the census, will be enabled to check any mistake made by the dietitian. The form of such stamp may be somewhat as follows:

This dietary requisition is based on the following number of persons
.....
Patients and Employees.....
Patients only.....
Employees only.....

The census on which such requisitions are based should be sent daily to the chef, and posted in the kitchen, so that he may know the number of persons for whom he is to prepare and issue food.

As a basis for estimating for budget purposes the amount of food required for a hospital for a year the schedule on page 608 is submitted. This schedule has been devised after reviewing the amount of different classes of food used by a large number of public hospitals and institutions. It is believed that the total amount of food provided is ample, and that the proportions of the various kinds of food are such as to secure a proper balance of food qualities. This schedule would provide 123.53 grams of protein and 3,533 calories per day for each of the general patients, which amount is ample. It will be noticed that for tuberculous patients it is suggested that an additional amount of 144 pounds of beef, veal, and mutton, 30 pounds of eggs, and 671 pounds of milk be provided.

This table provides 266 pounds of meat per capita per year for general hospitals, which is somewhat less than the amount now served in Bellevue Hospital. This amount of meat will provide 8 ounces per capita per day for patients, and 16 ounces for employees. The amount provided for patients is as large as that now served in Bellevue Hospital, but the amount for the employees is somewhat reduced. To show how this amount of meat could be distributed in daily rations the table on page 610 is suggested.

For the purpose of estimating the cost of the 1,500 pounds of food indicated for an ensuing year it is suggested that a study be made as to the feasibility of choosing certain leading articles, such as flour, potatoes, beef, mutton, butter, sugar, coffee, eggs, and milk, and determining their market value as quoted by certain recognized trade associations; the estimate of the total cost of food to be varied year by year, according to the variation of the market prices of these leading articles. The price of each article would have to be multiplied by the proportionate quantity to be furnished, as indicated by the table, and the total increase or decrease in the cost of the varieties mentioned be then considered the total increase or decrease of the aggregate amount for 1,500 pounds of food. In other words, if 1,500 pounds of food during the year ended cost $75.00, and of that amount the 9 leading varieties cost $50.00, and by comparison of current market rates it appears

that these leading varieties during the ensuing year will probably cost $55.00, or an increase of $5.00 over the previous year, then the total cost of the 1,500 pounds of food for the next year may be estimated to be $5.00 more than in the previous year, or an aggregate of $80.00. This estimate does not take into account any increases or decreases in the prices of the other varieties of food included in the table, as it is practically impossible to determine the changes in the prices of so many varieties, and inasmuch as they constitute a small proportion of the total expenditure their fluctuation in price is not material.

Suggested Basis for Estimating the Number of Pounds of the Different Kinds of Food to be Used in Municipal Hospitals.

The following list of foods contains all varieties except fresh fruits and fresh vegetables, some fancy groceries, and cooking accessories. The amounts given indicate the total number of pounds per capita per year. To determine the total amount of food required, the number of pounds per capita should be multiplied by the average census, including both patients and employees.

Articles	Pounds	
Flour and Wheat Products	290	
Corn Meal and Hominy	10	
Oats, Rolled and Meal	9	
Rice	7	
Beans and Peas (Dried)	10	
Potatoes	225	
Butter	30	
Cheese	1.5	
Sugar	45	
Molasses and Syrup	2	
Beef and Veal	150	(Add 144 lbs for Tbc.[1])
Mutton	30	
Pork	4	
Bacon	2	
Salt Pork	0.5	
Ham and Shoulder	5	
Lard	2	
Fish, Fresh	30	
Fish, Salt	3	
Poultry	40	
Dried Fruits	15	
Canned Vegetables	15	
Canned Fruits	10	
Coffee	11	
Tea	3	
Eggs	50	(Add 30 lbs for Tbc.[1])
Milk	500	(Add 671 lbs. for Tbc.[1])
Total	1,500[2]	

Note: The above amount of food would produce per capita per day 123.53 grams of protein and 3,533 calories. For tuberculous patients 181.20 grams of protein and 4,600 calories.

[1] For institutions having tuberculous patients only, the following amounts may be used:

	Patients	Employees
Meat	410 lbs.	266 lbs.
Eggs	80 "	30 "
Milk	1,171 "	430 "

[2] Good management should reduce the per capita consumption of food below 1,500 pounds per annum.

SUGGESTED BASIS FOR ESTIMATING THE NUMBER OF POUNDS OF THE DIFFERENT KINDS OF FOOD TO BE USED IN ALMSHOUSES.

The following list of foods contains all varieties except fresh fruits and fresh vegetables, some fancy groceries, and cooking accessories. The amounts given indicate the total number of pounds per capita per year. To determine the total amount of food required, the number of pounds per capita should be multiplied by the average census, including both inmates and employees.

Articles	Pounds
Flour and Wheat Products	340
Corn Meal and Hominy	10
Oats, Rolled and Meal	9
Rice	7
Beans and Peas (Dried)	8
Potatoes	275
Butter	20
Cheese	0.5
Sugar	45
Molasses and Syrup	2
Beef and Veal	130
Mutton	50
Pork	2
Bacon	2
Salt Pork	0.5
Ham and Shoulder	5
Lard	2
Fish, Fresh	35
Fish, Salt	2
Poultry	5
Dried Fruits	10
Canned Vegetables	2
Canned Fruits	2
Coffee	10
Tea	4
Eggs	10
Milk	150
Total	1,138

NOTE: The above amount of food would produce per capita per day 102.17 grams of protein and 3,195 calories.

Inasmuch as the schedule does not provide for fresh fruits, fresh vegetables, miscellaneous foods, and cooking accessories, it is suggested that $6.50 per capita per year be added to cover these items, which is about the amount expended for these articles by Bellevue Hospital.

The schedule of food submitted as a basis for estimating the total amount of food needed for a year provides 266 pounds of meat per capita per year for each employee and patient. If the census of Bellevue Hospital were 2,256 this ratio would provide 601,224 pounds. The table indicating the ratio in which this food would be distributed daily shows a distribution of but 551,803 pounds, so that the estimate provides for 49,421 pounds of food more than the distribution table requires. The trimming waste in the butcher shop would not exceed 1 per cent.

SUGGESTED MEAT RATIONS FOR MUNICIPAL HOSPITALS, WITH QUANTITIES BASED UPON THE CENSUS OF BELLEVUE HOSPITAL FOR 1912.

Kinds of Meat	Census, 1912		Ration Allowance in ounces		Meals per Week		Total Weeks Used	Total Meals per Year		Total Pounds per Year		Aggregate Total	Total According to the Ratios in the Schedule on Page 608
	Patients	Employees	Patients	Employees	Patients	Employees		Patients	Employees	Patients	Employees		
Beef and Veal	1,243	1,013	3	7	8	10	52	416	520	96,954	230,457	327,411	338,400
Mutton	1,243	1,013	3	8	2	2	26	52	52	12,119	13,169	25,288	67,680
Pork	1,243	1,013	5	7	2	2	26	52	52	20,197	11,523	31,720	9,024
Fresh Fish	1,243	1,013	5	7	2	2	52	104	104	40,394	23,046	63,440	67,680
Salt Fish		663		6		1	26		26			6,465	6,768
Salt Pork												1,128	1,128
Ham and Shoulder		663		5		1	52		52		10,111	10,111	11,280
Bacon		250		2		7	52		364		3,900	3,900	4,512
Lard												4,512	4,512
Poultry		663		10		1	52		52	[1]54,750	21,547	76,297	90,240
Poultry (Orderlies' Dining Room)		350		10					7		1,531	1,531	
Total												551,803	601,224
Excess to provide for trimming and waste													49,421

[1] This amount provides 1,050 lbs. per week for patients. At present they are receiving 720 lbs. per week.

AMOUNT OF PROTEIN AND NUMBER OF CALORIES IN FOOD PRODUCTS AS GIVEN IN BULLETIN No. 28 (REVISED), U. S. DEPARTMENT OF AGRICULTURE.

Articles	Per Cent. of Protein	Fuel Value per Pound Calories
Flour and Wheat Products	.104	1,635
Macaroni	.134	1,665
Corn Meal and Hominy	.092	1,665
Oats, Rolled and Meal	.167	1,850
Rice	.08	1,630
Beans and Peas	.225	1,605
Potatoes	.018	310
Butter and Butterine	.01	3,605
Cheese	.259	1,950
Sugar	.00	1,860
Syrup and Molasses	.024	1,290
Beef and Veal	.148	1,040
Mutton	.13	1,215
Pork	.08	2,215
Corned Beef	.143	1,271
Bacon	.091	2,795
Salt Pork	.074	2,655
Ham and Shoulder	.142	1,675
Lard	.00	4,220
Fresh Fish	.085	205
Salt Fish	.139	1,155
Poultry	.14	800
Dried Fruits	.028	1,350
Canned Vegetables	.02	300
Canned Fruits	.005	400
Eggs	.134	720
Milk	.033	325

NOTE: A pound contains 453.6 grams.

BELLEVUE HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1912.

Average Daily Census, Patients and Employees, 2,256.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	143.62	$5.25	14.94	234,819
Corn Meal and Hominy	4.23	.09	.39	7,043
Oats, Rolled and Meal	4.86	.15	.81	8,991
Rice	6.34	.26	.51	10,334
Beans and Peas (Dried)	5.23	.25	1.18	8,394
Potatoes	220.69	4.04	3.97	68,414
Butter	29.73	9.34	.30	107,177
Cheese	1.38	.23	.36	2,691
Sugar	42.77	2.38	.00	79,552
Molasses and Syrup	1.24	.09	.03	1,600
Beef and Veal	159.26	15.79	23.57	165,630
Mutton	82.53	6.74	10.73	100,274
Pork	11.38	1.45	.91	25,207
Bacon	4.62	.68	.42	12,913
Salt Pork	1.36	.12	.10	3,611
Ham and Shoulder	12.03	1.56	1.71	20,150
Lard	3.00	.32	.00	12,660
Fresh Fish	27.21	1.84	2.31	5,578
Salt Fish	1.36	.15	.19	1,571
Poultry	42.07	6.45	5.89	33,656
Dried Fruits	13.35	1.54	.37	18,022
Canned Vegetables	19.87	1.09	.40	5,961
Canned Fruits	13.86	1.35	.07	5,544
Coffee	13.95	2.92	.00	000
Tea	2.77	.40	.00	000
Eggs	75.31	11.95	10.09	54,223
Milk	589.32	16.53	19.45	191,529
Total	1,533.34	$92.96	98.70	1,185,544

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.19	$.0606	122.32	3,240

HARLEM HOSPITAL.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1912.

Average Daily Census, Patients and Employees, 329.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	135.35	$5.01	14.08	221,297
Corn Meal and Hominy	1.85	.04	.17	3,080
Oats, Rolled and Meal	3.39	.10	.57	6,272
Rice	3.72	.19	.30	6,064
Beans and Peas (Dried)	3.04	.16	.68	4,879
Potatoes	201.50	3.71	3.63	62,465
Butter	31.75	9.71	.32	114,459
Cheese	.71	.14	.18	1,385
Sugar	55.63	3.08	.00	103,472
Molasses and Syrup	1.91	.20	.05	2,464
Beef and Veal	185.53	22.84	27.46	192,951
Mutton	62.62	6.26	8.14	76,083
Pork	11.90	1.43	.95	26,359
Bacon	4.28	.54	.39	11,963
Salt Pork	.31	.02	.02	823
Ham and Shoulder	7.00	.99	.99	11,725
Lard	4.84	.54	.00	20,425
Fresh Fish	16.17	1.02	1.37	3,315
Salt Fish	.32	.04	.04	370
Poultry	79.55	12.05	11.14	63,640
Dried Fruits	11.05	1.30	.31	14,917
Canned Vegetables	21.16	1.20	.42	6,348
Canned Fruits	12.05	1.16	.06	4,820
Coffee	11.20	2.33	.00	000
Tea	2.86	.43	.00	000
Eggs	51.00	8.04	6.83	36,720
Milk	733.55	20.66	24.21	238,404
Total	1,654.24	$103.19	102.31	1,234,700

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.52	$.0624	126.80	3,373

GOUVERNEUR HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1912.

Average Daily Census, Patients and Employees, 434.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	125.48	$4.42	13.05	205,160
Corn Meal and Hominy	2.36	.05	.22	3,929
Oats, Rolled and Meal	3.59	.11	.60	6,642
Rice	1.88	.09	.15	3,064
Beans and Peas (Dried)	1.86	.08	.42	2,985
Potatoes	174.90	3.30	3.15	54,219
Butter	26.10	8.13	.26	94,091
Cheese	.77	.18	.20	1,502
Sugar	39.50	2.24	.00	73,470
Molasses and Syrup	1.14	.06	.02	1,471
Beef and Veal	185.80	21.16	27.50	193,233
Mutton	44.14	4.79	5.74	53,630
Pork	4.83	.60	.39	10,698
Bacon	2.48	.36	.23	6,932
Salt Pork	.46	.04	.03	1,221
Ham and Shoulder	15.67	2.16	2.23	26,247
Lard	.79	.09	.00	3,334
Fresh Fish	17.59	1.15	1.50	3,606
Salt Fish	.25	.03	.03	288
Poultry	47.57	7.24	6.66	38,056
Dried Fruits	8.03	.94	.22	10,841
Canned Vegetables	16.83	.93	.33	5,049
Canned Fruits	12.07	1.11	.06	4,828
Coffee	8.61	1.81	.00	000
Tea	2.42	.40	.00	000
Eggs	89.11	14.10	11.94	64,160
Milk	658.62	18.98	21.73	214,052
Total	1,492.85	$94.55	96.66	1,082,707

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.08	$.0633	119.80	2,959

FORDHAM HOSPITAL.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1912.

Average Daily Census, Patients and Employees, 307.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	137.07	$4.64	14.25	224,109
Corn Meal and Hominy	6.74	.14	.62	11,222
Oats, Rolled and Meal	6.25	.19	1.04	11,563
Rice	4.41	.22	.35	7,188
Beans and Peas (Dried)	4.51	.23	1.01	7,239
Potatoes	168.60	2.71	3.03	52,266
Butter	34.98	10.88	.35	126,103
Cheese	1.21	.19	.31	2,360
Sugar	51.82	2.93	.00	96,385
Molasses and Syrup	2.15	.20	.05	2,774
Beef and Veal	165.51	17.60	24.50	172,130
Mutton	84.24	7.17	10.95	102,352
Pork	16.11	1.93	1.29	35,684
Bacon	4.35	.64	.40	12,158
Salt Pork	.29	.03	.02	770
Ham and Shoulder	13.85	1.68	1.97	23,199
Lard	2.23	.24	.00	9,411
Fresh Fish	23.10	1.31	1.96	4,736
Salt Fish	.51	.06	.07	589
Poultry	83.44	12.53	11.68	66,752
Dried Fruits	19.96	2.37	.56	26,946
Canned Vegetables	22.71	1.26	.45	6,813
Canned Fruits	18.74	1.72	.09	7,496
Coffee	15.70	3.29	.00	000
Tea	4.47	.65	.00	000
Eggs	55.98	8.83	7.50	40,306
Milk	547.44	15.35	18.07	177,918
Total	1,496.37	$98.99	100.52	1,228,469

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.09	$.0661	124.58	3,356

METROPOLITAN HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1911.

Average Daily Census, Patients and Employees, 2,295.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	280.20	$6.58	29.14	458,127
Corn Meal and Hominy	12.54	.19	1.15	20,879
Oats, Rolled and Meal	7.42	.17	1.24	13,727
Rice	5.68	.23	.45	9,258
Beans and Peas (Dried)	10.28	.44	2.31	16,499
Potatoes	161.52	2.15	2.91	50,071
Butter	27.68	7.24	.28	99,786
Cheese	1.26	.19	.33	2,457
Sugar	43.54	2.12	.00	80,984
Molasses and Syrup	1.82	.08	.04	2,348
Beef and Veal	191.25	16.65	28.30	198,900
Mutton	29.22	2.64	3.80	35,502
Pork	2.54	.30	.20	5,626
Bacon	1.39	.22	.13	3,885
Salt Pork	2.55	.24	.19	6,770
Ham and Shoulder	3.58	.49	.51	5,996
Lard	.88	.09	.00	3,714
Fresh Fish	28.01	1.48	2.38	5,742
Salt Fish	7.72	.66	1.07	8,917
Poultry	32.73	4.99	4.58	26,184
Dried Fruits	16.83	1.83	.47	22,720
Canned Vegetables	6.22	.30	.12	1,866
Canned Fruits	5.18	.43	.03	2,072
Coffee	11.08	2.01	.00	000
Tea	3.76	.46	.00	000
Eggs	86.26	12.82	11.56	62,107
Milk	741.37	18.43	24.47	240,945
Total	1,722.51	$83.43	115.66	1,385,082

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.72	$.0484	143.74	3,795

CITY HOSPITAL.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Patients and Employees, 1,235.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	290.95	$7.13	30.26	475,703
Corn Meal and Hominy	5.59	.09	.51	9,307
Oats, Rolled and Meal	9.05	.21	1.50	16,742
Rice	3.84	.16	.31	6,259
Beans and Peas (Dried)	12.21	.49	2.75	19,597
Potatoes	224.35	2.97	4.04	69,548
Butter	32.81	8.71	.33	118,280
Cheese	1.56	.23	.40	3,042
Sugar	46.84	2.27	.00	87,122
Molasses and Syrup	1.20	.05	.03	1,548
Beef and Veal	190.65	16.85	28.22	198,276
Mutton	44.83	4.20	5.83	54,468
Pork	4.54	.55	.36	10,056
Bacon	2.79	.46	.25	7,798
Salt Pork	.08	.01	.01	212
Ham and Shoulder	5.48	.76	.78	9,179
Lard	1.12	.12	.00	4,726
Fresh Fish	31.13	1.89	2.64	6,381
Salt Fish	3.92	.33	.54	4,528
Poultry	38.49	6.30	5.39	30,792
Dried Fruits	16.54	1.58	.46	22,329
Canned Vegetables	15.20	.71	.30	4,560
Canned Fruits	8.94	.75	.04	3,576
Coffee	10.82	1.95	.00	000
Tea	3.64	.50	.00	000
Eggs	53.97	8.07	7.23	38,858
Milk	588.85	15.08	19.43	191,376
Total	1,649.39	$82.42	111.61	1,394,263

Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
4.52	$.0499	138.70	3,820

KINGS COUNTY HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1911.

Average Daily Census, Patients and Employees, 1,127.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	175.78	$4.33	18.28	287,400
Corn Meal and Hominy	6.23	.10	.57	10,373
Oats, Rolled and Meal	5.19	.13	.87	9,601
Rice	2.44	.10	.20	3,977
Beans and Peas (Dried)	3.35	.12	.75	5,377
Potatoes	222.80	2.98	4.01	69,068
Butter	32.16	8.48	.32	115,937
Cheese	.65	.10	.17	1,267
Sugar	43.25	2.10	.00	80,445
Molasses and Syrup	.93	.03	.02	1,200
Beef and Veal	174.40	16.48	25.81	181,376
Mutton	43.27	3.85	5.62	52,573
Pork	6.45	.80	.52	14,287
Bacon	3.62	.57	.33	10,118
Salt Pork	.40	.04	.03	1,062
Ham and Shoulder	6.39	.87	.91	10,703
Lard	.77	.08	.00	3,249
Fresh Fish	26.06	1.83	2.21	5,342
Salt Fish	6.03	.50	.84	6,964
Poultry	16.20	2.78	2.27	12,960
Dried Fruits	9.87	1.00	.28	13,325
Canned Vegetables	10.91	.53	.22	3,273
Canned Fruits	7.81	.68	.04	3,124
Coffee	11.66	2.01	.00	000
Tea	3.61	.45	.00	000
Eggs	48.63	7.31	6.52	35,014
Milk	507.61	14.10	16.75	164,973
Total	1,376.47	$72.35	87.54	1,102,988

Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
3.77	$.0525	108.79	3,021.88

CUMBERLAND STREET HOSPITAL.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Patients and Employees, 272.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	156.29	$3.65	16.25	255,534
Corn Meal and Hominy	4.41	.07	.41	7,343
Oats, Rolled and Meal	13.35	.32	2.23	24,698
Rice	3.31	.13	.26	5,395
Beans and Peas (Dried)	9.93	.39	2.23	15,938
Potatoes	236.95	3.19	4.26	73,454
Butter	29.79	7.82	.30	107,393
Cheese	1.65	.26	.43	3,217
Sugar	66.10	3.19	.00	122,946
Molasses and Syrup	2.15	.08	.52	2,773
Beef and Veal	142.15	13.13	21.04	147,836
Mutton	46.35	4.11	6.02	56,315
Pork	6.05	.74	.48	13,400
Bacon	3.36	.53	.31	9,391
Salt Pork	1.47	.14	.11	3,902
Ham and Shoulder	5.54	.76	.79	9,279
Lard	2.21	.24	.00	9,326
Fresh Fish	7.85	.40	.67	1,609
Salt Fish	13.43	1.13	1.87	15,512
Poultry	17.72	3.04	2.48	14,176
Dried Fruits	18.02	1.82	.50	24,327
Canned Vegetables	15.87	.77	.32	4,761
Canned Fruits	11.66	.99	.06	4,664
Coffee	11.24	1.93	.00	000
Tea	5.36	.73	.00	000
Eggs	26.14	3.97	3.50	18,820
Milk	482.53	13.04	15.92	156,822
Total	1,340.88	$66.57	80.96	1,108,831

Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
3.67	$.0496	100.61	3,038

CONEY ISLAND HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1911.

Average Daily Census, Patients and Employees, 150.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	205.64	$5.23	21.39	336,211
Corn Meal and Hominy	5.17	.08	.48	8,608
Oats, Rolled and Meal	7.67	.18	1.28	14,190
Rice	4.00	.16	.32	6,520
Beans and Peas (Dried)	3.60	.14	.81	5,778
Potatoes	293.60	4.00	528	91,016
Butter	37.89	10.05	38	136,593
Cheese	2.39	.38	.62	4,661
Sugar	82.44	4.00	.00	153,338
Molasses and Syrup	2.53	.13	.06	3,264
Beef and Veal	230.39	21.45	34.10	239,606
Mutton	63.59	5.70	8.27	77,262
Pork	9.13	1.11	.73	20,223
Bacon	5.33	.84	.49	14,897
Salt Pork	2.00	.20	.15	5,310
Ham and Shoulder	9.60	1.31	1.36	16,080
Lard	3.96	.43	.00	16,711
Fresh Fish	29.73	1.97	2.53	6,095
Salt Fish	13.40	1.06	1.86	15,477
Poultry	27.89	4.63	3.90	22,312
Dried Fruits	17.16	1.74	.48	23,166
Canned Vegetables	24.30	1.11	.49	7,290
Canned Fruits	21.35	1.90	.11	8,540
Coffee	5.33	2.62	.00	000
Tea	5.77	.81	.00	000
Eggs	3.09	4.99	4.43	23,825
Milk	1.15	12.33	15.55	153,124
Total	1,628.10	$88.55	105.07	1,410,10

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.46	$.0543	130.57	3,863

BRADFORD STREET HOSPITAL.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Patients and Employees, 11.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	279.91	$7.25	29.11	457,652
Corn Meal and Hominy	1.91	.03	.18	3,180
Oats, Rolled and Meal	4.08	.10	.68	7,548
Rice	4.64	.18	.37	7,563
Beans and Peas (Dried)	4.46	.17	1.00	7,158
Potatoes	340.27	4.64	6.12	105,483
Butter	70.00	18.46	.70	252,350
Cheese	1.82	.28	.47	3,549
Sugar	84.84	4.18	.00	157,802
Molasses and Syrup	4.00	.42	.10	5,160
Beef and Veal	166.36	15.51	24.62	173,014
Mutton	89.73	8.30	11.66	109,021
Pork	22.18	2.72	1.77	49,128
Bacon	27.09	4.26	2.46	75,716
Salt Pork	2.18	.20	.16	5,788
Ham and Shoulder	33.36	4.57	4.74	55,878
Lard	3.18	.33	.00	13,419
Fresh Fish	26.36	2.37	2.24	5,403
Salt Fish	6.82	.44	.95	7,877
Poultry	73.63	13.14	10.31	58,904
Dried Fruits	9.64	.84	.27	13,014
Canned Vegetables	67.09	3.10	1.34	20,127
Canned Fruits	51.09	4.33	.26	20,436
Coffee	33.63	6.07	.00	000
Tea	2.73	.47	.00	000
Eggs	104.27	15.70	13.97	75,074
Milk	527.09	14.30	17.39	171,304
Total	2,042.36	$132.36	130.87	1,861,548

Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
5.59	$.064	162.63	5,100

NEW YORK CITY HOME FOR THE AGED AND INFIRM, MANHATTAN.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Inmates and Employees, 3,017.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	348.78	$8.09	36.27	570,255
Corn Meal and Hominy	2.23	.03	.21	3,712
Oats, Rolled and Meal	6.47	.15	1.08	11,969
Rice	6.21	.26	.50	10,122
Beans and Peas (Dried)	8.39	.33	1.89	13,465
Potatoes	215.37	2.82	3.88	66,764
Butter	15.49	4.15	.15	55,841
Cheese	.38	.06	.10	741
Sugar	59.94	2.87	.00	111,488
Molasses and Syrup	1.07	.27	.03	1,380
Beef and Veal	126.79	9.96	18.76	131,862
Mutton	75.51	6.18	9.81	91,744
Pork	1.73	.21	.14	3,831
Bacon	2.15	.36	.20	6,009
Salt Pork	12.00	1.18	.89	31,860
Ham and Shoulder	.35	.06	.05	586
Fresh Fish	27.72	1.37	2.36	5,683
Salt Fish	.15	.01	.02	173
Poultry	7.64	1.22	1.07	6,112
Dried Fruits	17.30	1.65	.48	23,355
Canned Vegetables	.16	.08	.00	48
Canned Fruits	.95	.08	.00	380
Coffee	10.52	1.88	.00	000
Tea	4.08	.48	.00	000
Eggs	11.97	1.80	1.60	8,618
Milk	150.54	4.56	4.97	48,925
Total	1,113.89	$50.11	84.46	1,204,923

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	3.05	$.0449	104.96	3,301

NEW YORK CITY HOME FOR THE AGED AND INFIRM, BROOKLYN.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Inmates and Employees, 1,653.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	252.97	$6.17	26.31	413,606
Corn Meal and Hominy	10.49	.17	.97	17,466
Oats, Rolled and Meal	9.78	.25	1.63	18,093
Rice	5.66	.23	.45	9,226
Beans and Peas (Dried)	5.35	.20	1.20	8,587
Potatoes	197.89	2.62	3.56	61,346
Butter	25.69	6.87	.26	92,612
Cheese	.22	.04	.06	429
Sugar	43.24	2.11	.00	80,426
Molasses and Syrup	.17	.01	.01	219
Beef and Veal	150.43	11.98	22.26	156,447
Mutton	14.94	1.32	1.94	18,152
Pork	1.30	.24	.10	2,880
Bacon	.59	.09	.05	1,649
Salt Pork	1.33	.14	.10	3,531
Ham and Shoulder	.89	.12	.13	1,490
Lard	.06	.01	.00	253
Fresh Fish	33.50	1.65	2.84	6,867
Salt Fish	9.21	.76	1.28	10,638
Poultry	5.66	.83	.79	4,528
Dried Fruits	9.72	.99	.27	13,122
Canned Vegetables	1.99	.09	.04	597
Canned Fruits	1.92	.16	.01	768
Coffee	16.93	2.82	.00	000
Tea	4.52	.53	.00	000
Eggs	10.58	1.60	1.41	7,618
Milk	101.84	3.99	3.36	33,098
Total	916.87	$45.99	69.03	963,648

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	2.51	$.0501	85.79	2,640

NEW YORK CITY FARM COLONY.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Inmates and Employees, 766.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	343.57	$8.46	35.73	561,736
Corn Meal and Hominy	4.92	.08	.45	8,192
Oats, Rolled and Meal	10.65	.24	1.78	19,702
Rice	2.58	.11	.21	4,205
Beans and Peas (Dried)	13.07	.54	2.94	20,977
Potatoes	154.63	1.30	2.78	47,935
Butter	13.60	4.11	.14	49,028
Cheese	3.43	.54	.89	6,689
Sugar	31.10	1.47	.00	57,846
Molasses and Syrup	1.51	.45	.04	1,948
Beef and Veal	146.57	12.79	21.69	152,433
Mutton	31.26	2.81	4.06	37,980
Pork	2.30	.32	.18	5,095
Bacon	1.72	.31	.16	4,807
Salt Pork	8.44	.94	.62	22,408
Ham and Shoulder	1.81	.21	.26	3,031
Lard	.52	.06	.00	2,194
Fresh Fish	8.25	.50	.70	1,691
Salt Fish	6.76	.57	.94	7,808
Poultry	7.20	1.34	1.01	5,760
Dried Fruits	16.83	1.76	.47	22,720
Canned Vegetables	5.69	.30	.11	1,707
Canned Fruits	3.76	.30	.02	1,504
Coffee	11.27	1.99	.00	000
Tea	5.98	.77	.00	000
Eggs	5.91	1.07	.79	4,255
Milk	201.15	6.48	6.64	65,374
Total	1,044.48	$49.82	82.61	1,117,024

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	2.86	$.0476	102.66	3,060

NEW YORK CITY CHILDREN'S HOSPITALS AND SCHOOLS.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Patients and Employees, 2,059.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	277.21	$6.91	28.83	453,238
Corn Meal and Hominy	5.14	.08	.47	8,558
Oats, Rolled and Meal	4.69	.11	.78	8,676
Rice	5.89	.25	.47	9,600
Beans and Peas (Dried)	6.48	.25	1.46	10,400
Potatoes	187.78	2.46	3.38	58,211
Butter	21.98	5.82	.22	79,238
Cheese	.01	.00	.00	20
Sugar	43.98	2.12	.00	81,820
Molasses and Syrup	.21	.00	.01	270
Beef and Veal	125.99	10.75	18.65	131,030
Mutton	27.06	2.19	.35	32,877
Pork	3.02	.37	.24	6,689
Bacon	.90	.15	.07	2,515
Salt Pork	1.46	.15	.11	3,876
Ham and Shoulder	2.83	.37	.40	4,740
Lard	.58	.06	.00	2,448
Fresh Fish	16.68	.82	1.42	3,419
Poultry	10.96	1.78	.15	8,768
Dried Fruits	13.05	1.21	.36	17,617
Canned Vegetables	2.73	.12	.05	819
Canned Fruits	1.99	.16	.01	796
Coffee	4.83	.87	.00	000
Tea	2.04	.28	.00	000
Eggs	25.26	3.78	3.38	18,187
Milk	522.22	14.32	17.23	169,721
Total	1,314.97	$55.38	78.04	1,113,533

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	3.60	$.0421	96.97	3,051

MUNICIPAL LODGING HOUSE.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1911.

Average Daily Census, Lodgers and Employees, 561.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	286.74	$6.62	29.82	468,819
Corn Meal and Hominy	1.25	.02	.11	2,081
Oats, Rolled and Meal	26.02	.42	4.34	48,137
Rice	1.87	.08	.15	3,048
Beans and Peas (Dried)	5.16	.50	1.16	8,282
Potatoes	142.37	1.90	2.56	44,135
Butter	10.57	2.67	.11	38,105
Cheese	.97	.14	.25	1,892
Sugar	43.07	2.06	.00	80,110
Molasses and Syrup	.20	.01	.00	258
Beef and Veal	113.67	10.71	16.82	118,217
Mutton	13.58	1.23	1.76	16,500
Pork	1.89	.23	.15	4,186
Bacon	2.28	.39	.21	6,373
Salt Pork	2.50	.23	.19	6,638
Ham and Shoulder	3.35	.46	.48	5,611
Lard	1.47	.16	.00	6,203
Fresh Fish	22.19	1.99	1.89	4,549
Salt Fish	.18	.02	.02	208
Poultry	14.41	2.68	2.02	11,528
Dried Fruits	5.54	.58	.16	7,479
Canned Vegetables	3.42	.15	.07	1,026
Canned Fruits	1.32	.12	.00	528
Coffee	23.84	4.17	.00	000
Tea	.97	.12	.00	000
Eggs	16.28	2.46	2.18	11,722
Milk	321.57	7.82	10.61	104,510
Total	1,066.68	$47.94	75.06	1,000,145

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	2.92	$.0449	93.28	2,740

MUNICIPAL TUBERCULOSIS SANATORIUM, OTISVILLE, N. Y.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1912.

Average Daily Census: Patients, 487; Employees, 35; Total, 522.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	137.22	$4.56	14.07	224,355
Corn Meal and Hominy	10.44	.24	1.06	17,383
Oats, Rolled and Meal	10.67	.32	1.78	19,739
Rice	4.90	.28	.39	7,987
Beans and Peas (Dried)	18.14	1.00	4.08	29,115
Potatoes	222.45	6.34	4.00	68,960
Butter	58.20	17.74	.58	209,811
Cheese	3.50	.53	.10	6,825
Sugar	72.62	4.09	.00	136,073
Molasses and Syrup	2.08	.10	.05	2,683
Beef and Veal	277.84	31.76	41.12	288,943
Mutton and Lamb	151.43	16.99	19.69	183,987
Pork	14.12	1.81	1.13	31,276
Bacon	9.95	1.65	.91	27,810
Salt Pork	4.00	.37	.30	10,620
Ham	27.56	4.19	3.91	46,163
Lard	4.38	.53	.00	18,484
Fresh Fish	21.79	1.81	1.85	4,467
Salt Fish	3.32	.30	.46	3,835
Poultry	59.02	10.69	8.26	47,216
Dried Fruits	29.15	3.33	.82	39,352
Canned Vegetables	16.53	.97	.33	4,959
Canned Fruits	18.35	1.77	.09	7,340
Coffee	9.17	2.04	.00	.00
Tea	3.41	.65	.00	.00
Eggs	63.03	10.18	8.45	45,381
Milk	1,194.29	28.46	39.41	388,144
Total	2,447.56	$152.70	152.84	1,870,908

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	6.67	$.0624[1]	189.93	5,126
	.....	.0767[2]	.....	.....

[1] Including home productions.
[2] Not including home productions.

KINGSTON AVENUE HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1912.

Average Daily Census, Patients and Employees, 408.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	110.75	$5.30	11.52	181,076
Corn Meal and Hominy	.50	.11	.05	832
Oats, Rolled and Meal	13.98	.43	2.34	25,863
Rice	3.40	.18	.27	5,542
Beans and Peas (Dried)	5.29	.26	1.19	8,490
Potatoes	126.61	2.45	2.28	39,249
Butter	25.60	7.88	.26	92,288
Cheese	.45	.07	.12	878
Sugar	50.20	2.90	.00	93,372
Molasses and Syrup	.98	.06	.02	1,264
Beef and Veal	56.28	6.07	8.33	58,531
Mutton	39.75	4.56	5.17	48,296
Pork	4.61	.57	.37	10,211
Bacon	2.92	.39	.27	8,161
Salt Pork	1.01	.12	.07	2,682
Ham and Shoulder	16.95	2.22	2.41	28,391
Lard	.81	.09	.00	3,418
Fresh Fish	16.19	1.56	1.38	3,319
Salt Fish	4.61	.39	.64	5,325
Poultry	20.66	3.64	2.89	16,528
Dried Fruits	17.98	1.84	.50	24,273
Canned Vegetables	26.37	1.35	.53	7,911
Canned Fruits	15.30	1.38	.08	6,120
Coffee	14.39	3.09	.00	000
Tea	2.46	.46	.00	000
Eggs	34.96	5.54	4.68	25,171
Milk	758.86	20.78	25.04	246,630
Total	1,371.87	$73.69	70.41	943,821

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	3.75	$.0537	87.26	2,578

WILLARD PARKER HOSPITAL.

FOOD CONSUMPTION, COST, AND VALUE—YEAR ENDED DECEMBER 31, 1912.

Average Daily Census, Patients and Employees, 549.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	141.52	$5.05	14.72	231,385
Corn Meal and Hominy	2.76	.05	.25	4,595
Oats, Rolled and Meal	9.42	.29	1.57	17,427
Rice	2.50	.13	.20	4,075
Beans and Peas (Dried)	3.52	.16	.79	5,650
Potatoes	195.06	3.72	3.51	60,469
Butter	31.54	9.65	.32	113,702
Cheese	.26	.04	.07	507
Sugar	41.40	2.38	.00	77,004
Molasses and Syrup	.32	.03	.01	413
Beef and Veal	147.15	15.69	21.78	153,036
Mutton	70.07	7.92	9.11	85,135
Pork	7.01	.87	.56	15,527
Bacon	5.01	.68	.46	14,003
Salt Pork	.75	.09	.06	1,991
Ham and Shoulder	27.62	3.73	3.92	46,254
Lard	.50	.05	.00	2,110
Fresh Fish	19.88	1.83	1.69	4,075
Salt Fish	2.62	.24	.36	3,026
Poultry	20.05	3.53	2.81	16,040
Fruits, dried	10.63	1.08	.30	14,351
Canned Vegetables	19.50	1.01	.39	5,850
Canned Fruits	8.79	.84	.04	3,516
Coffee	10.54	2.28	.00	000
Tea	2.81	.51	.00	000
Eggs	22.00	3.40	2.95	15,840
Milk	852.42	22.66	28.12	277,037
Total	1,655.65	$87.91	93.99	1,173,018

	Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
	4.52	$.0531	116.48	3,205

RIVERSIDE HOSPITAL.

Food Consumption, Cost, and Value—Year Ended December 31, 1912.

Average Daily Census, Patients and Employees, 548.

Articles	Pounds of Food per Capita	Average Cost per Capita	Protein Pounds per Capita	Fuel Value Calories per Capita
Flour and Wheat Products	162.74	$6.52	16.92	266,080
Corn Meal and Hominy	1.10	.04	.10	1,832
Oats, Rolled and Meal	11.02	.34	1.84	20,387
Rice	5.29	.28	.42	8,623
Beans and Peas (Dried)	8.07	.38	1.82	12,952
Potatoes	283.77	5.47	5.11	87,969
Butter	37.57	11.51	.38	135,440
Cheese	.75	.11	.19	1,463
Sugar	72.77	4.20	.00	135,352
Molasses and Syrup	.70	.05	.02	903
Beef and Veal	227.96	24.68	33.74	237,078
Mutton	80.43	9.36	10.46	97,722
Pork	15.70	1.92	1.26	34,776
Bacon	10.10	1.42	.92	28,230
Salt Pork	5.00	.57	.37	13,275
Ham and Shoulder	45.54	6.18	6.47	76,280
Lard	.01	.00	.00	42
Fresh Fish	21.45	2.14	1.82	4,397
Salt Fish	5.47	.48	.76	6,318
Poultry	53.12	9.27	7.44	42,496
Dried Fruits	32.36	3.41	.91	43,686
Canned Vegetables	38.78	1.89	.78	11,634
Canned Fruits	10.56	.88	.05	4,224
Coffee	17.29	3.65	.00	000
Tea	4.63	.85	.00	000
Eggs	68.74	10.45	9.21	49,493
Milk	986.57	26.60	32.56	320,635
Total	2,207.49	$132.65	133.55	1,641,287

Consumption per Day	Average Cost per Pound	Grams per Day	Calories per Day
6.03	$.0601	165.51	4,484

2. CHARACTER AND COSTS OF HOSPITAL BUILDINGS

FOREWORD

It is desirable to know whether our hospital buildings are well planned and economically built. It seemed to be advisable in connection with the inquiry carried on by the Committee to examine such elements of the cost of the various hospital buildings as might give a basis of comparison in designing buildings yet to be built.

It was considered best to make the examination from two standpoints: first, to ascertain the complete cost of individual buildings and to subdivide these costs on a basis of bed capacity; and, second, to have an examination made of the buildings by a thoroughly competent hospital architect who would be able to point out some of the most obvious errors in planning and construction. The examination of costs was made by Mr. John P. Fox, of New York City, and the inspection of the buildings was made by Mr. Edward F. Stevens, architect, of Boston.

It is not assumed that the criticisms made by Mr. Fox and Mr. Stevens will call for any material alterations in existing buildings. The criticisms are designed primarily to show wherein errors were made in the original planning and how such errors may be avoided in future buildings.

The buildings have been grouped in classes; such as nurses' homes, dormitories, tuberculosis pavilions, and ward buildings; and the buildings in each class compared with an arbitrary standard. In each case the standard was based on a building of fireproof construction, in use, or in course of erection, or about to be erected, which seemed to the Committee to be most suitably and economically planned. Each standard selected has a cost price of 30 cents per cubic foot, and inasmuch as a number of hospital buildings of the Departments of Charities and Health have been constructed for this amount of money it seemed fair to adopt 30 cents per cubic foot as a reasonable standard cost. Good hospital buildings are, and should be, built for this amount of money at the present time. When the bids for any of the hospital buildings of New York City materially exceed this amount per cubic foot examination should be made to ascertain to what the excess cost is due; whether faulty planning, expensive material, or insufficient competition in bidding.

EXAMINATION OF BUILDINGS

BOSTON, MASS., October 8, 1913.

MR. HENRY C. WRIGHT, *Director,*

Committee on Inquiry into Departments of Health, Charities, and Bellevue and Allied Hospitals of the Board of Estimate and Apportionment.

New York City.

SIR:—

Pursuant to your request that I investigate the newer buildings erected and in course of erection for the Departments of Health, Charities, and Bellevue and Allied Hospitals, and recommend some standard of work and planning which would be helpful in passing upon the plans of future hospital buildings of the City of New York, I would report:

That I have visited many of the new and a few of the older buildings of the Departments; have made notes; studied the plans, materials, and expense of the same; have compared the planning with the best planned hospitals of Europe and America; and have endeavored to ascertain the classification of patients cared for in the Departments. From my own observation of the housing of the sick in all countries I would offer:

1st. A few suggestions of standards gathered from my own experience and from a study of the best examples throughout the world, or at least of what would appear to be the essentials of the buildings of the different groups.

2nd. An opinion of where, in my judgment, existing buildings of the above Departments could be made more efficient and where in future buildings many errors which have crept into some of the existing structures may be avoided.

Many of the buildings of the Departments were planned before the real needs of a hospital were known. Some were planned without due study, on the part of the designer, of the real needs of the buildings; but in the later buildings the improvement is very marked, both in planning and detail.

The housing of the great multitudes of people who come under the care of the Departments of Charities, Health, and Bellevue and Allied Hospitals is a study that in itself should have years instead of days in which to make a comprehensive report.

The Site

In planning any institution the first thing to be considered is the site. The weather conditions, the exposure, the environment, all have to do with the shape, the material used, and the nearness to other buildings.

As a rule, it might be safe to procure enough land on all sides of the proposed buildings to ensure for all time free circulation of air and sunshine.

The future could be considered in placing any new building and, so far

as possible, the entire group should be blocked out and the grouping made so that the buildings planned for a certain purpose can always be used for that purpose. This idea is being carried out fully by the Department of Health, I understand, in its new hospital at Jamaica.

The best location for the central plants, such as kitchens, laundries, and heating plants should be determined upon: for the kitchen, one sufficiently central for quick delivery of food; for the laundry, the best location of service; for the heating plant, preferably a lower grade and far enough away so that the smoke will not reach the patients' buildings. If one group of buildings is near another it is always economy to have one central heating and lighting plant and, under certain conditions, one central laundry and baking plant.

If a sloping site is considered the slope should not be toward the north, as the shadows cast by the buildings would be longer, and consequently the ground colder than with a southerly slope.

At Blackwell's Island I found five institutions, all belonging to the municipality of New York City. Each institution had its own heating, lighting, and laundry plants. One central heating and lighting plant could be maintained at vastly less expense. A central laundry where all the clothes could be laundered would also tend to lessen the running expense.

At Kings County Hospital and Kingston Avenue Hospital, both owned by the City, two separate heating plants exist where one could be made to do the work, with a saving of labor and fuel.

In many cases I found electricity being purchased from public service plants when the steam generated for laundry and heating purposes could have been passed through generating engines without appreciable loss.

The Ward Unit

Every hospital is or should be planned for one purpose; and that is, the best care of the patient. Around this one object the institution should be built. That this requires administrative buildings, homes for attendants, heating, lighting, washing, and food supply units, is only that the patient may have the best care.

The ward unit should be planned for the classification of the disease which is to be treated. The conditions which govern the treatment of acute surgical patients are different from those governing chronic medical. The ambulatory tuberculous patient needs different accommodations from the patient suffering from the same disease in an advanced form; the child from the adult; the contagious from the psychopathic.

A few essentials might be mentioned: I believe that whatever the classification of the patient, the ward or bed of the patient should be so placed that it would be possible to have sunshine in the room or near the bed some part of the day; and that all necessary inside doors, and all doors or windows giving access to porches, should be designed wide enough for the patient to be moved, bed and all, to any part of the building, porches, or roof without discomfort or inconvenience.

As to the number of beds to be placed in any ward, authorities differ very much. The best German, Dutch, and Danish authorities believe that not more than 16 to 18 patients should be in one room, and some believe that these should be subdivided with screens for a better segregation.

The height of the ceiling may depend upon the classification of the patients, but any height above 12 feet is unnecessary and of little use in the

purification of the air, as the breathing line is about 3 feet from the floor. On the other hand, a ward of more than 10 beds should not be less than 10 or 11 feet in height. Every patient should have, when all windows and doors are closed, at least 1,000 cubic feet of air, or, on a 12-foot basis, 83 square feet of floor surface.

There should always be a quiet room with 1 or 2 beds near each ward for a delirious or dying patient.

Roof Ward

Many of our modern hospitals have, for economy's sake, a flat roof. Some of the hospitals utilize this roof to a certain extent. It is my opinion that every ward unit should have its roof used as a roof ward, not merely a flat tiled roof where a patient may be wheeled, but a practical roof ward, partly covered for protection from storms and intense heat, and partly open for the direct rays of the sun. The regular ward service of serving kitchen, toilet and sink rooms, linen and supply room, should also be provided so that the patient may spend continuous time in the open.

Serving Kitchen

Every ward unit should have the serving kitchen of sufficient size, and so placed as to allow of quick service of palatable food. There should be facilities for the keeping of food, warm or cold; for cooking small diets; for laying of the trays for the patients; and for washing the ward china. All cases for china and supplies should be free from the walls, as should all plumbing fixtures.

The common fault of most serving kitchens is to make them too small; and the arrangement of the equipment is often very inconvenient. Such rooms should be carefully planned around the equipment, instead of the equipment having to be adapted to the room after the building has been built; and the equipment most used should be located so as to be most accessible, with things adjacent that are needed together, in order to save time and confusion.

Day Room

The day, or convalescent, room is considered so important by the German Government that every German hospital must, by law, provide a day room for every ward unit. This day room is about 10 per cent. of the area occupied by the patients' rooms, or about 9½ square feet to each patient, and it is used by convalescents for dining and recreation.

Sink Room

It is always necessary to have a separate room for the emptying, sterilizing, and storage of bedpans and urinals, and similar ward service. In this room the soiled clothes container may be placed, unless clothes chutes are used. The local incinerator is sometimes found valuable for the destroying of ward waste and may be placed in this room. Here also should be placed the gas stove for the making of poultices, the ice crusher for ice caps, the small ice storage box, the blanket warmer, etc.

Owing to the constant use of this room, as well as the serving kitchen, the walls should be tiled to at least a working height.

Ward Toilets

The simplest form of plumbing should be used for the ward toilets; water closets of a substantial construction, with cut-away "crescent" seats, and plumbing pipes as little exposed as possible. The wash bowls or trays should be serviceable and solid; a spray supply to permit washing under running water is considered more hygienic than the old style of bowl where one is constantly washing in soiled water.

The subdividing partitions between toilets should be solid, of marble or slate, with doors having springs to hold them open.

Bathroom

In the acute cases little use is made of the bathtub, so that in the general surgical or medical ward unit only a limited number will be needed. In the tubercular ward unit, however, ample bathing facilities should be provided, both for tub and shower, where bathing forms a part of the treatment. In any case where the patient needs assistance in being bathed the tub should be elevated from the floor. In the children's ward, where the bath is given by an attendant, the high shallow slab or tub, with spray, should be used. The overflow should be accessible, and all pipes so planned that they can be cleaned at least to the water line of the trap, both exterior and interior.

Linen Room

There should be a separate storage of linen for each ward unit. The linen and blankets should have a well ventilated room, and shelves or racks should be open and well ventilated.

Surgeons' Bowls

There should be a sufficient number of scrub-up bowls in each ward unit, either in the ward or corridors, to enable the visiting surgeon or physician to scrub between each examination, without walking too great a distance.

Division of Floor Space

From a careful investigation of modern ward units now under construction for the care of general cases—of from 18 to 24 beds per floor—it has been found that an average of 25 per cent. of the area is needed for utilities, staircases, and elevators, and 25 per cent. for corridors, leaving 50 per cent. for patients. Circumstances will, of course, change these proportions. In wards for contagious diseases the proportion for utilities would be greater, while for incipient tuberculosis the proportion for utilities would be less.

Lighting

The lighting of the ward unit by day or night is important. The beds should be placed so as to shield the patients' eyes, and the night light should be so obscured that the lighting of it for night inspection would not necessarily awaken the patients. Direct ceiling lights should be avoided; reflected lights give a softer and more agreeable light. A wall outlet at each bedside provides for examination.

Portable lights have disadvantages, as they are not always available when wanted, or are too far away. The best arrangement for bedside lighting has been found to be a portable lamp, which, when not on the table, can be hung up on the wall out of the way.

For pleasant lighting of wards in the daytime the new arrangement of beds found in the Rigs Hospital at Copenhagen seems to give good satisfaction. In this plan all the beds are parallel to the outside wall. None of the patients face the light, the windows being at one side; while the screens between the groups of beds tend to hide other windows.

For curtains the ordinary roller shade is not nearly so satisfactory as the German drapery curtains. The latter can easily be removed for washing, and can be made to overlap at the center.

Color of the Ward Walls

The therapeutic effect of color is very marked on some patients. Soft, cheerful colors and decorations should therefore be chosen, and in the children's wards simple and amusing pictures could be used with great success.

Nurses' Calls

The use of the silent electric light call for nurses is quite as effectual as bells, and less disturbing to the patients. A similar system would apply to internes' calls.

Floors

The problem of the best material for floors for hospital purposes is difficult to solve, and authorities differ. In the study of the newer European hospitals one finds that flint tile is perhaps used more than any other floor material, except linoleum. These tiles should be as large as 4 inches, and either square or hexagonal, laid with a coved base.

Terrazzo forms an inexpensive floor, with perhaps as good results as any simple material. Two colors may be used, one for the base and one for the field, with the dividing line made by a line of single tesseræ.

Many of the magnesite floors are giving good results; these are put down in a plastic form and in varying colors, and give a pleasing, artistic effect. I have found, however, that this material is apt to disintegrate under certain conditions.

A wood floor, if well laid and kept clean, is fairly satisfactory; but its numerous cracks render it less hygienic.

Where strictest economy must be practiced, a good quality of cement is recommended as having served its purpose well in many an institution.

The use of linoleum is growing in this country, and it seems to me that when properly applied on a smooth surface it becomes the most satisfactory floor covering for the wards, private rooms, and corridors. If the newer colors and patterns of the German linoleum are used the effect is very pleasing.

Perhaps the best material for corridor floors, where there is much traffic, is pressed cork tile, this being even more resilient than linoleum and better for heavy wear.

All of the asphalt materials should be avoided, except for special conditions requiring acid-proof qualities in the floor.

The quarry tiles make a most artistic and satisfactorily wearing floor for the service portion of the building and for roof wards and airing balconies.

Examples of, and Comments on, Ward Units

Riverside Hospital

The new pavilions for tuberculous cases appear to be well built and very economically planned. The only question is whether too much economy has not been practiced. The ceiling heights of 9 feet, while sufficient when the windows are all open, would seem too low when the windows have to be closed on account of wind or storms. The bathing facilities for patients consist of a set basin for every 5 patients and a tub or shower for every 10. This is hardly sufficient for the best practice.

There is no utility room provided in the ward unit, a practice which appears universal in the Department of Health and seems to work all right, probably owing to the splendid management of the Superintendent.

There is no isolation or quiet room on each floor, though such a room may not be needed for the class of cases to be treated.

There are no balconies of any kind, their use being considered unnecessary because of the large size of the windows. While the casement windows do give a large opening, it appears questionable whether they will prove to be satisfactory, especially those which open out and whose fastenings do not appear strong enough to withstand hard wear and heavy winds. Indeed, one window on one of the new buildings was found to have been completely blown away.

One omission in the buildings which it is proposed to remedy is that of lockers for the patients' belongings, which now have to be kept in boxes at the heads of the beds. In new buildings it would seem advisable to have patients' lockers on every floor, if not individual dressing rooms, such as are found in the plans of the latest tuberculosis buildings at Otisville.

The lighting provided for the wards is too glaring, being furnished by large frosted ceiling globes, with no indirect lights. These fixtures were required, I am told, by the Department of Water Supply, Gas, and Electricity.

Kingston Avenue Hospital

The new admitting unit is well planned, providing for separate service if necessary to every room on the ground floor. This is developed on an improved Pasteur unit, except that in the Pasteur there are several direct air passages across the building between the utility rooms and the patients' cubicles.

The detail of interior finish is unnecessarily heavy, and expense could have been avoided by the use of plain wood sashes and doors instead of all being metal covered. The steel door frames are good.

As the building is not finished and no equipment in place it would be hard to judge of the efficiency of the plan; but it has much to commend it and bids fair to be an ideal admitting unit.

The measles and scarlet fever pavilions were examined, but require no special comment as they seem to adequately meet the needs.

Willard Parker Hospital

The scarlet fever pavilion, which has been in use eight years, is in splendid condition, except the solarium on the roof, which has leaked badly, owing to poor construction, and is not used. The building was an expensive one, which can be accounted for by such things as an elaborate ventilating system, a considerable height of floors; viz., 14 feet 6 inches, and the extensive use of tiling for all the floors.

The new measles pavilion, practically completed but not equipped, is excellently planned, and worked out in every detail with proper regard to the essentials for economical administration and serving the patients, and is one of the best developed plans I have seen.

In the admitting department of the first floor each patient is put into a separate or private room, having glazed partitions on the corridor side to facilitate observation. A Dutch door opens to the outer airing balcony. A water closet and a bowl are provided in each room.

The only improvement I could suggest to this plan would be to have cut-offs between the patients' rooms and the utilities, as seen in the Pasteur Hospital in Paris.

In the upper stories the wards are subdivided with glass screens for a better segregation and classification.

Solaria and airing balconies are provided on all floors, and outdoor vented clothes chutes are provided.

This building has set a standard as to what an isolation hospital for contagious diseases should aim for.

Sea View Hospital

There are certain features about the general plan of Sea View Hospital which are good. The location of the administration building, of the main kitchen, storerooms, and dining rooms, is central and convenient. The position of the power house on the west side of the buildings is not the best to insure freedom from smoke, although the height of the chimney may prevent any trouble arising from it.

The radiation of the ward buildings from a semicircular corridor which surrounds the administrative group is ingenious, but throws all ideas about the proper orientation of hospital buildings to the winds, literally; for the axes of the buildings lie in almost every direction from north and south to east and west. If a south exposure is the best for a tuberculosis ward, only two of the buildings have much of their sides towards the south. If a north and south direction is the best for the axis of a ward building, as believed by many hospital authorities, then only two buildings conform to this plan. The "T"-shaped arrangement of the 3 wards on each floor still further complicates the way the beds face.

There is little to be seen in the plan or on the exterior of the Hospital to suggest its being a tuberculosis institution. The large dining rooms and the broad airing balconies on each side of each floor would seem to indicate a tuberculosis hospital, although such balconies belong to general hospitals as well as to those devoted to the treatment of tuberculosis.

One feature of the arrangement of buildings will prove expensive in the matter of operation, and that is the number of elevators. There are 8 elevators in the ward buildings, each requiring an operator. If each operator works eight hours, then 24 operators will be required. With a hospital located in the country, with unlimited land in sight, it would seem

as though the ward buildings could have been designed either low enough to avoid elevators, or else grouped or connected so as to reduce the number to a minimum.

One good feature of the ward buildings is the provision of small wards; 3 on each floor of all but two buildings, the largest wards in the latest buildings having 16 beds.

There is nothing about the administrative end of the ward buildings to suggest provision for tuberculosis, and there is a decided lack of needed facilities. The bathing facilities are insufficient for patients, with only 1 bathtub and 1 shower on each floor, for from 25 to 29 patients, and these are both in the same room, with no privacy whatever. The wash basins in some of the buildings are shut off from the outside light by a high partition, which is not satisfactory, either for light or air.

The large hydrotherapeutic room on the first floor of the ward buildings could not be considered either ideal or economical, for the majority of the patients for this treatment should be under the direct charge of a physician who would prescribe individual treatment for individual cases, and should, I believe, be placed in a central bath house or bath department, and the more simple and natural bathing facilities provided where the patients themselves could take their baths.

It is my opinion that lockers should be provided on every floor, where each patient could keep his own personal belongings and wraps. These can be taken care of to some extent in the patients' ward bedside tables, but for ambulatory patients these lockers should be provided.

The sink rooms are very complete, indeed too complete. There is certainly an excess of pressure sterilizers, as 3 are provided for each floor, or nearly 100 for the group. This number could have been reduced by two-thirds.

The medicine closets appear unnecessarily elaborate and expensive, with too many locks and keys. Poisons should be properly protected, but a multiplicity of locks seems hardly necessary in a well managed hospital.

The ward kitchens appear too small for the number of beds on a floor. While a considerable proportion of the patients are expected to go to the main dining rooms for their meals, for the wards where this will not occur it would have seemed wiser to provide a larger and more convenient space for serving meals to bed patients.

The linen closets, which should be of the simplest construction, are lined and even ceiled with red cedar, with close shelving—an unnecessary expense for an institution where the linen and blankets are being changed nearly every day.

The plumbing fixtures, while of good make, were not designed with reference to simple care and cleanliness.

The floors, which appear to be of a good quality of wood, should be of some material with fewer cracks, as linoleum, terrazzo, or magnesite composition.

A curious inconsistency is the use of a terrazzo base with the wooden floor. Since wood was used for the floor, it might just as well have been used for the base; for it could have had the same cove and been made flush with the plaster above.

The detail of the finish is heavy, which might have been almost entirely eliminated by the use of non-projecting finish.

The balconies are convenient to all 3 wards on a floor. The number of doors leading directly to balconies might have been reduced by making

every second opening a window. This, too, would have allowed the placing of the direct radiators under the windows and between the beds, instead of at the head, as at present arranged, where they may prove to be too near the patients' heads.

The radiators should have been of a type more easily cleaned, with wider spaces between the sections.

While the environment of a patient has its effect on the recovery or depression of the individual, and while he should be surrounded as far as possible with beautiful grounds, cheerful colors, and plenty of sunshine and fresh air, it would not seem that the lavish use of the exterior ceramic decorations could be considered as having any therapeutic effect upon the class of patients that will occupy the building.

The surgical building was unnecessarily expensive in the lavish use of wall and ceiling tiles. Some of the details are good. The operating department, too, is elaborate to a fault. The absolute separation of the aseptic and septic rooms is uncalled for. That is to say, the general service rooms might well be the same, with a separate operating room for septic cases. The method of humidifying the air and other complicated details might well have been omitted.

The connecting corridors are well lighted, but unnecessarily elaborate. The expensive method of opening the corridor doors might be criticised from an economical standpoint, both as to construction and maintenance.

The kitchen, service building, etc., will be mentioned under the proper headings.

City Hospital

As there are no recently erected ward units at City Hospital there are no comments to be made, except in commendation of the splendid condition in which the old buildings, after half a century of use, were found. The crowding of the wards, though necessary, is of course to be deplored, as many of the patients are at a great distance from the outside light and air.

In the admitting unit, though an old and poorly planned building, the patients were well taken care of, their clothes cleansed, pressed, and hung up as carefully as in a Fifth Avenue clothing store.

The kitchen, laundry, and grounds will be mentioned under their respective headings.

Metropolitan Hospital

The only new ward buildings are the tuberculosis pavilions. The best feature of these are the wide airing balconies, on both the east and west sides of the wards. The wards were originally planned for 14 beds, 7 on each side, with doors between every 2 beds to give access to the balconies. In the new wing of the east pavilion, now under construction, this multiplicity of doors has been changed to the arrangement suggested for Sea View, that is, with alternating doors and windows, getting the radiators further away from the patients' heads.

In the existing tuberculosis pavilions, where many of the patients go outside to their meals in a common dining room, no advantage was taken of this fact to make a larger use of the administration section. In the pavilion under construction the floors have been carefully planned with proper regard for the patients who will go out to eat and those who will be

fed in the building. As a result, an increase of 14 per cent. in the number of beds has been possible.

A further economy has been effected in the utility rooms, which in the older building had considerable unnecessary plumbing.

The oldest parts of Metropolitan Hospital are in a remarkably good condition, testifying to the able administration of the energetic Superintendent. The new operating rooms in the old rotunda have been very carefully thought out, and are very complete in their arrangements.

In planning the newer buildings, it seems a mistake to have kept to the style and material of the older buildings, which suggest too much the penal institutions on the Island. Of all buildings, those of a hospital ought to be made as cheerful as possible; and while a uniformity is often desirable in architecture in constructing new buildings, it is certainly out of place when it tends to make a hospital look like a prison or workhouse. There is all the more reason to change the type of building on Blackwell's Island in view of the fact that the stone used is itself of a dark and gloomy color, and also because there is, so I understand, practically only one quarry where it can be obtained, which, if true, would tend to put the City at the mercy of the owners of the quarry.

The new buildings at Kings County Hospital set an excellent standard for a cheerful color and attractive style of architecture. In view of the greater prominence of the buildings on Blackwell's Island it would seem very desirable to begin now to make them as pleasing as those of Kings County Hospital.

The grounds on the Island are being transformed by means of grading, grass and tree planting, and cultivation of flowers.

The chapel at Metropolitan Hospital is a very pleasing contrast to the other buildings in its lighter color and Gothic style. The new domestic building as planned will also be Gothic, but the material will still be the dark stone.

Kings County Hospital

The older buildings of this Hospital are in surprisingly good condition, considering their age, and constant improvements have been made.

The new ward building has some of the best ward features found. The placing of one wing of the building at an obtuse angle with the other wing, for the evident purpose of some outside architectural effect, is hardly to be commended; but the putting of the utilities in the center between the two ward wings is a good feature, conducive to economy. Each of the 2 wards on a floor has its own patients' toilet, but only 1 kitchen and 1 utility room are required, these being of ample size.

The main wards have 22 beds each, and are unnecessarily wide as now used. But this width lends itself to a trial of the Rigs ward idea. By putting in low screen partitions, set out from the walls to allow passing by, more beds can be introduced than now; the patients more easily segregated; and greater comfort afforded them.

The new ward building has an airing balcony at only one end; but also has a large solarium or day room on each floor, with a fire tower opening out of it. There are 2 small quiet rooms on each floor, for 3 patients each, located away from the wards and all possible disturbances.

The details of the building are better than usual, though some things might be improved. The doors have a heavy wooden trim, which is un-

necessary, but they are properly rounded at the bottom, and the curved base of the walls is carried around the door frames.

The ward and hall floors are of a magnesite composition, which does not make a good appearance.

The walls and ceilings are finished with white enamel paint, which looks very clean but is really too bright, and will be more or less uncomfortable for the patients.

The wards are lighted by 8 inverted ceiling lights, another example of too much light as required by the Department of Water Supply, Gas, and Electricity.

An excellent feature of the administration section of this ward unit is a basin in the hall, convenient for a physician or nurse to wash hands.

The new children's ward building, just occupied, shows careful planning, with proper subdivisions and ample outdoor space for the children. The wards are sunny and each one opens on to an airing balcony. The roof also will be utilized, having a playroom as well as the open space. The wards are well adapted for subdivision by screens, so as to permit more beds and a better classification of patients. In the case of children, the screens should have sections of glass, to allow better supervision. The wards are equipped with basins, facilitating the washing of hands by physician or nurse. The toilet rooms have slabs for the washing of children. There are no utility rooms, the toilet rooms also containing the slop sinks.

The wards, and corridors also, have an over-supply of electric light, and the lights are so arranged that they must all be turned on or off at the same time.

The least satisfactory feature of the children's building is the condition of some of the floors, most of which are of linoleum, laid on concrete. The concrete was not smoothed off enough before laying the linoleum and the latter, as a result, is uneven in places.

Bellevue Hospital

The plans of Pavilions A and B of the new buildings are in many ways extravagant, both as to floor heights and disposition of the general utilities. It is my opinion that the comfort of the patients has been sacrificed too much to architectural lines, although the architecture of the buildings, in spite of the sacrifice, is somewhat disappointing.

These pavilions are obviously too close together, especially for their height, and should have faced the south instead of the east, which would have given better ventilation and more light. The arrangement of rooms leaves much to be desired. The toilet, bath, and utility rooms are practically all one, which certainly should not be the case with such large wards. The bathtub is in line with the door, which opens on an inner corridor, making it apparently impossible to wheel a patient into the room on a stretcher.

There is no separate day room for the patients, the dining table for those who can walk to their meals being located in half of the ward kitchen. As originally planned the building had no roof wards with proper utilities. The wood finish of the wards and rooms is unnecessarily heavy. Steel door frames would have been just as cheap as the oak ones, and the projecting corners and angles could have been avoided. One elevator is certainly insufficient for a building with nearly 400 beds.

One of the most questionable features of the wards is the small number of windows. Instead of having a window on each side of every bed, as is considered the best practice, there is only 1 window to every 2 beds, and a space on both sides of the wards has 3 beds against a blank wall without any window. The restricted size of the court makes the rooms dark, especially on the lower floors, while the loggia adds to the darkening, and the windows do not go up to the ceiling on all the floors. This is not altogether surprising, however, because one floor is 18 feet 6 inches high and another 15 feet 8 inches, with the rest 15 feet, all much higher than necessary for hospital floors, the air space above 12 feet being generally considered of no value. All the ceilings at Bellevue are over 12 feet in height, the excess ranging from about 1½ feet to 6½ feet.

The radiators are of a type not easily cleaned, and the openings into the ventilating ducts are covered with gratings instead of being free from all obstructions to catch dust.

Pavilions L and M, now under construction, show marked improvements over A and B. The most conspicuous changes are those evidently initiated by the medical expert for the hospital, Dr. Goldwater. It is unfortunate that it was considered necessary to carry out the architectural lines of the first buildings, but the most has been made of the space. The administration rooms have been greatly improved. Toilet, utility, and bathrooms have been separated and better arranged. A day room has been provided, opening out of the ward kitchen. A freight elevator has been added. Very complete roof wards have been provided, with kitchen, toilet, and dressing rooms, and permanent roofs for shelter. Some of the details might have been improved, but probably for the sake of uniformity with the first buildings no changes were made. The same heavy wood finish has been preserved, and a cast iron rail has been added to the walls to prevent stretchers from injuring the plaster.

The floors, which are of wood in A and B, are being laid with plastic linoleum, a magnesite composition; of rather uncertain value because magnesite flooring does not give uniformly good results.

The plumbing fixtures appear too complicated and should be set farther away from the wall. Each ward will have a basin near the farther end, which will be very useful. The bathtub, as in A and B, is in the way of the door and wheel stretchers.

The heating radiators would be better if hung from the walls. The clothes chute is very large, measuring 48 inches by 39 inches inside. But in spite of any shortcomings the new pavilions are a great improvement over A and B.

In the other new buildings which Dr. Goldwater has planned or is planning for Bellevue he has made the most of a restricted situation, and worked out most interesting plans, so that the institution promises to be a very practical one, in spite of the early mistakes and architectural demands.

Nurses' Residence

Perhaps next in importance to the care of the patient is the care of the nurse, for to do her best and to give proper care and comfort to the unfortunate sick a nurse must conserve her own health and strength. When "off duty" she must have somewhere to go; out of the environment of the sick room; out of the sound of groaning and suffering patients.

I believe that this point should be borne in mind in planning a home for

nurses: that the more attractive and homelike the nurses' building, the more alluring the position seems to be to the young woman who is taking up nursing for her life work. Consequently, a better class of women will be attracted; and, the better the nurse, the better the care of the patient.

As her work when on duty is most confining, the nurse, whether pupil or graduate, should have a separate room, not necessarily large, but large enough for a single bed, closet, dresser, and study desk. This can be accomplished in an area 8 feet 8 inches by 12 feet.

There should be ample reception rooms for the receiving of friends, study rooms on each floor, a little tea kitchen for the occasional "spread," a petty laundry for the nurses' own use, and ample toilet and bathing facilities on every floor. There should be both shower and tub baths.

It is my opinion that bowls supplied with hot and cold water should be placed in every room, as this will economize time and tend to greater cleanliness.

In the larger homes it is desirable that a separate kitchen and dining room be provided in the building, but in the smaller institutions separate dining rooms adjoining the kitchen building tend to greater economy.

An infirmary for sick nurses should be provided in every large home, with hospital provision for the care of a limited number of nurses.

Provision should be made for the nurse to sleep out of doors, either on a sleeping porch or upon a balcony.

The nurses' residences at nearly all hospitals of the Departments of Charities, Health, and Bellevue and Allied Hospitals visited have been given careful and thoughtful consideration for the comfort of the nurses. Some of the residences are still planned for 2 or more nurses in a room, but all provide comfortable sitting and study rooms for the nurses.

The Nurses' Home at Metropolitan Hospital is well arranged and surrounded by a beautiful garden on the water-front, which adds to its attractiveness. The kitchen and dining rooms are in the same building.

The Home at Kings County Hospital, with its rest rooms, its study rooms, and sleeping balconies, its gymnasium and roof garden, has the charm of a private residence. The cost of this modern building was perhaps slightly in excess of some of the other homes, but I believe that the attractions of the Home will tend to keep it filled with desirable nurses.

The Kitchen

Next in importance to the nursing of the sick is the feeding; and how to serve not only good but palatable food to patients scattered over an area of many acres is one of the problems most difficult to solve.

In many of the great hospitals in Europe, where institutions occupy great space and are served "over ground"—that is, without covered corridors—the food is taken in special electric trolley cars, as in the case of the Steinhof at Vienna; or in the General Hospital at Utrecht, where heated push cars running on tracks are provided; or in the great Virchow or St. Georg, where food is carried in insulated cars.

The kitchen should be in close touch with the storerooms and refrigerating rooms, and at the same time should be centrally located. In a large institution it should be in a separate building.

Opinion differs greatly as to where the kitchen should be, whether in the upper portion of the domestic building, carrying all supplies up and taking all food down; or on the ground floor, the dining rooms above, and the

service on the ground floor level. There is much to be said in favor of either way. If the kitchen is up, there is less opportunity on the part of the yard man, for instance, "dropping in" and possibly "sampling" some of the good things and taking another sample for his friend. This would not happen were the kitchen on the upper floor. If there is an overhead connection to one of the upper floors of the ward building, one moving process is eliminated and time is saved; or in a group of buildings where there are first story or basement corridors, as in the Bispebjerg Hospital at Copenhagen, I consider the kitchen on the ground floor level conducive to quicker service.

The kitchen should be well ventilated. For this the top story would be the best location.

If all of the equipment is set out from the walls, it may be used and cleaned with greater facility.

Gas ranges, where gas is available, are generally more satisfactory than coal, as there is no dust or dirt from the fire; and, with the modern gas ranges, there is greater economy. Gas bakers are fast taking the place of the brick ovens, occupying one-tenth the space and having greater efficiency.

Every kitchen should have its diet kitchen in close contact, where the special diets are prepared and where much of the training of the nurses is done.

Steam can be used largely in cooking.

With the great improvements in electric appliances, much of the cooking can be done quickly, and also economically, where the current is generated on the premises.

The new kitchen of City Hospital is well planned and is on the third story, with direct "bridge" connection to the ward building. This facilitates quick service.

The kitchen at Kings County Hospital, built on the same general plan, has proven very efficient; but the glass tile walls have proven too fragile for the heavy work of the department.

The new kitchen of Sea View Hospital, built on the first floor, with storerooms below, bids fair to be one of the most successful in the City. The ranges are located in the center and steam cookers along the walls, with bakery, diet kitchen, and scullery in close proximity. The dining rooms for the ambulatory patients are arranged at either side of the main kitchen, but no serving rooms are provided, the plan being to serve directly from the ranges.

The food for the wards will be distributed from the kitchen by a unique system of distribution, designed by the architect after the principle of the familiar cash carrier system in stores. The food will be taken by electric overhead carriers and delivered automatically to just the right floor in the right building. One cannot help feeling that a good deal of reliance is being placed on an untried system, which may be very hard to operate in case of a breakdown, as it is difficult of access in the tunnel.

General Stores

There must be some general storehouse for each institution. This can be planned in connection with one of the domestic buildings, preferably the kitchen. The general stores should be under the charge of a competent steward, who would receive and receipt for all materials received at the institution, and who would be responsible for them. If the pharmacy is

located in another portion of the grounds, the druggist should receive all articles for that department. But great care should be taken not to have too many exits from the department for general supplies, and there should be every facility for receiving, weighing, and storing in a proper way all meats, fruits, and vegetables in quantities.

The Laundry

The planning of the laundry should be considered the same as the planning of a factory, to economically transform the crude material into the finished product. From the time the soiled clothes enter until the clean and folded goods go out there should be no unnecessary carting backward and forward; but the machines should be so planned and arranged that the goods will go steadily forward to completion. If the sorting of the soiled clothes is done into boxes on trucks, the boxes can be wheeled at once to the washers. If the washers are large, with all the modern improvements, 1 washer properly built will do the work of 3 improperly constructed.

If the extractors are grouped together, one man can run the group, and so the line of body and hand ironers should be in line with the dry room and conveyers. The mangle and hand ironers should be near the linen room.

Light and air are essentials and the linen or stock room should be well ventilated, with shelves of slate, to allow a free circulation of air.

It is economy to have the stock linen room and the washed linen storeroom in one, so that the requisitions can be quickly filled without replenishing the stock from the general storeroom. Here all of the linen should be mended and other sewing done.

Should the location demand a multi-storied building, the laundry or washing work should be started at the top and finished ironing done below. An elevator will take the material up and its own weight will bring it down.

The laundries of the Department of Health at Riverside Hospital and Kingston Avenue Hospital seemed especially well arranged and handled. At both places the clothing is all brought into a receiving room, cut off from the rest of the laundry by a sealed steel partition, into which are built sterilizing washers. The dirty clothes are put into these washers, and are removed on the inner side only when thoroughly washed and sterilized. The newer laundry at Kingston Avenue Hospital has an excellent linen room, and efficient methods of keeping track of the laundry and supplies.

The new laundry at City Hospital was not in operation, so that little can be told about it. Gas instead of electric irons were in use in all these laundries, in deference to the unfortunate requirements of the Department of Water Supply, Gas, and Electricity.

The new laundry at Sea View Hospital contains elaborate sterilizers, although the Department of Health seems not to need them for a like class of patients.

Staff Residence and Help's Quarters

In every great hospital unit it is essential to have proper quarters for the staff, and for the male and female employees, as well as for the nurses.

The medical students who are giving their time for years and attending the sick should be provided with good, attractive quarters where they can work, study, and enjoy themselves. These, however, should not be too palatial, but should possess home comforts.

Dormitories

Male and female help should, I believe, be provided with single rooms, however small. A room no larger than 7 feet by 10 feet would be vastly better than sleeping in a large dormitory full of uncongenial people. The help, too, should have some place for sitting, reading, and recreation; for, unless they can secure entertainment within a building they may seek it outside at some worse place.

The only help's quarters at Sea View Hospital, as yet, are those in the Nurses' Home, for help working in the Home. These consist practically of cubicles located in the attic, a few lighted by outside windows, but most of them by overhead skylights. It is a very economical arrangement, but can hardly help being cramped and hot in summer.

The best dormitories seen were those at Metropolitan Hospital. The building for male help will have some open dormitory rooms, which the Superintendent thinks are better for some of the men employed than individual rooms. For women, he believes in individual rooms. The female dormitory is a very commodious one, with large bedrooms, sitting rooms, and accommodations about as good as those of an ordinary nurses' home. This may be going too far toward the other extreme.

The dormitory for males at Bellevue Hospital was originally designed to have nothing less than 2 beds in a room; but, not being full, a number of the best grade of employees, such as clerks, etc., have single rooms to themselves. The other rooms contain from 2 to 5 beds. This doubling up of employees is said to be unsatisfactory, and to cause dissatisfaction or dissensions which result in men leaving the service. The desire of the architects to have the floors in this building of the same height as in all the other buildings has led to the extreme height of floors already mentioned in connection with ward pavilions. No dormitory needs a floor 18 feet 6 inches high, or even 15 feet, as the majority of them are; a height of even 9 feet 6 inches being sufficient. If the architectural lines of the other buildings had not been followed, and one or two more floors had been put into the present building, it seems probable that every man could have been given a single room, at very little extra expense and without increasing the dimensions of the building. No economy was practiced in furnishing space for recreation, to which the roof floor and the basement are given over, with a bowling alley in the sub-basement. If some of this space had been put into single rooms it might have gone farther in making the employees satisfied. The toilet facilities, though well located and arranged, are fewer for the number of beds than in any other dormitory visited. Like the other new Bellevue buildings, the wooden trim is unnecessarily heavy.

Administration Unit

While I have mentioned the units in order of importance from the patient's standpoint, the administration is, of course, the center around which all of this machinery revolves; and while it is one of the last buildings to be built, it is all important in its place in the group.

The Massachusetts General Hospital, built 100 years ago, is just about to have its administration building, so that it is possible to conduct the administrative office in the ward or other units.

In the smaller institutions of from 200 to 500 beds the administrative building often contains the superintendent's residence, the staff house, and

some of the other departments; such as the pharmacy, the Röntgen ray department, the admitting unit, etc. This building should, therefore, be central, and should contain, besides the superintendent's offices, space for bookkeeper, stenographer, and record rooms.

The only very recently built administration building found was that at Sea View Hospital. This is centrally located and very elaborately planned —indeed, too elaborately planned. The 2 extensive suites of examination rooms, for women and for men, would seem designed more for an acute hospital in a city, where patients are arriving in large numbers, than for an institution for the treatment of tuberculosis. The more logical place for elaborate examinations would also appear to be in the City, before the patients are shipped for the long trip to Sea View.

Plumbing

Hospital plumbing, so far as the pipes, drains, and vents are concerned, is no different from that for any other building of like grade, but the fixtures should be designed or selected for the purpose for which they are to be used. As far as possible these fixtures should stand clear of the walls, for two reasons: to facilitate cleaning, and prevent vermin. For, if the wall immediately behind the fixture is protected with tile, even though the adjoining surface be plaster, the ill effects of spattering will not be serious.

The traps, if set high near the fixture, can readily be cleaned to the water line, if the strainer is made removable. This prevents the accumulation of filth in the pipes.

Bathtubs, when used for patients, should be set up from the floor, for two reasons: to facilitate cleaning underneath, and to permit ease of bathing if performed by nurse or attendant. The inlets should be large, allowing the full discharge of hot and cold water at the same time. The type of inlet used on the ocean steamships allows of quick filling. The overflow, if any (and I question the need of an overflow if the bath is given by an intelligent attendant), should be easily cleaned. A plug or standpipe should be used, and not a "flow back" form of concealed standpipe.

It is my belief that the only way to be sure that a patient is thoroughly bathed is to use a bathing slab or shallow tub set high and used merely as a drain for the water. Then use a hose spray and actually wash the patient in clean running water. All of the dirt then goes directly to the drain and is not diluted and then used again on the body. This form of washing slab should be used in admitting patients, particularly in the contagious and children's departments. In many of the German and Austrian hospitals this form is used in the women's hospitals entirely.

In bathing children with a spray, it should be made impossible for the water to flow too hot through the spray; for a baby, unlike a grown person, may not give warning of being scalded.

Where a portable tub is needed an improvement can be made over the ordinary tub on wheels, which is heavy, clumsy, and too low. A much more convenient arrangement is a light copper tub, only a few inches deep, mounted on a wheel stretcher frame. If used in an isolation room, where running water and a floor outlet are provided, the patient could be bathed by a spray at the end of a hose attached to a faucet, while the waste water could reach the floor outlet through another hose.

Many of the so-called "clinic" hoppers are simply a complicated mass of valves, pedals, and sprays, which would need a mechanician to operate and

keep in order. The simpler the fixture the more effectual. If a sterilizing hopper is wanted, one should be secured in which all of the contents are sterilized, and which can be easily cleaned and repaired.

A sufficient number of wash basins should be placed in the ward, or in the corridor near the wards, and in private rooms, for the use of the surgeon in scrubbing up before and after examination. This is one of the greatest safeguards against cross infection.

The surgeons' operating scrub-up bowls or sinks have undergone many transitions during the past few years, and have passed from the complicated pedal valve, through the less complicated knee valve, to the absolutely simple elbow valve and spray. For the surgeon who scrubs under the running water, only a spillway is needed, and in some of the finer European hospitals a hard marble trough is used. The valves should be solid and easy working.

The new water closet, hung from the wall, is (where construction will permit) a great improvement. This type is being used in many institutions. The seats are an important item; if covered with celluloid and cut away in front they are much easier to clean.

For flushing purposes the flushing valve is coming into greater favor, but is more likely to get out of order than a regular tank; and its installation should be adopted with some hesitation unless a competent man is always available for repair work. The porcelain low tank appears to be the most satisfactory kind for flushing closets, being the most reliable and accessible device.

For the finish of plumbing pipes, every part requiring polishing should be reduced to a minimum; for the care of brasswork in some institutions is quite an item of expense. For connections between fixtures and soil pipes, rough brass castings have been found satisfactory, as they can be painted with aluminum paint.

The plumbing of an institution should be standardized as far as possible, and the use of too many special types avoided.

The plumbing seen in the buildings visited does not, as a whole, come up to these standards, although there were exceptions where excellent ideas had been introduced. As properly designed fixtures cost but little, if any, more than those in stock, it would seem well to give more attention to such an important detail.

Heating and Ventilating

The much discussed problem of how to properly heat and ventilate a hospital building or the ward units of a hospital has still many unsettled points: whether we should conduct the air to the ground floor, heat the same, send it through the building warmed, washed, and humidified, and forced into the closed room under thermostatic control at a given temperature night and day, a system the perfect working of which necessitates the closing of all windows and doors; or whether the better system is the simple form of putting the heating units in the room and introducing the air directly below or, as in the new General Hospital at Vienna, directly above the radiator. With the latter system, the opening of windows improves rather than defeats the results. It is my belief, borne out by many medical men, that the patient in bed should not have a high degree of temperature in the room except in special cases, and that nature calls for changes in temperature. The man in robust health demands it. Why should the patient who is building up his strength be denied it?

The ventilation of the ward or room is important. The breathed air should be exhausted, and the means for ventilation so located as to ensure the complete circulation of air. If the room is large, the vents should be at top and bottom, with a damper, so that the air can be drawn from one or the other.

The vent ducts should start at the floor, extending the floor material to the back of the flue, or the bottom of the flue should be curved so that no dust would remain. In no case should register faces be used.

Except in special cases, no rooms where patients are in bed should be heated above 68 degrees in winter weather.

As the New York buildings were visited in summer it was impossible to judge the results of existing heating and ventilating methods; but in no place did the methods, as far as seen, appear ideal, although some of the buildings had good details, as in the type of radiator used and the openings of the vent ducts.

Hospital Details

The exterior details of the hospital should be made to conform to the style of architecture in which the building is designed and should be left to the architect, it being borne in mind that the detail and exterior decoration should be subservient to the plan. In other words, the exterior should be designed around the plan and not the plan made to suit the elevation, which is so often the case. Care, however, should be exercised to establish units in the planning; to have the plumbing of one story come near the plumbing of the others, and to have the partitions continuous.

The "trim" of the windows and doors in the patients' quarters should have much thought, to avoid projecting surfaces and so facilitate the cleaning of the rooms. If the door jambs are made of pressed steel to the suitable form, with corners rounded and set to form a ground for the plaster, there will be no projection. To avoid the usual sharp angles at the juncture of the door jamb and floor the door stop should be omitted for a few inches from the floor and the coved base allowed to run through the jamb.

The base can be made of the same material as the jamb, coved, and brought out to meet the floor; or the base may be of marble, terrazzo, or other enduring material. If a slight projection 3 or 4 inches from the wall is made in the floor part of the base, a furniture stop should be provided which will keep the wall free from damage by furniture.

It is my opinion that the use of transoms over doors should be limited to utility rooms, but if used in wards the panels should be solid and not glazed, as glazed transoms allow the lighting of the corridors to disturb the patients at night. Where transoms are used the projecting transom rail should be avoided, and a rail the thickness of the sash supplied.

The windows should be placed low, so that the patient in bed can readily see out.

A simple system of introducing fresh air into the ward is to provide a "ventilating apron" at the lower part of the window, allowing air to enter, but without draught.

The doors should be smooth, without mouldings, and no thresholds should be permitted. All angles, whether floor, wall, or ceiling, should be coved.

The walls back of all plumbing fixtures should be tiled, with tile on the same surface and even with the plaster. The walls of the toilet and sink

rooms, the serving kitchens and laboratories, and similar rooms subject to much use should be tiled to a height of 5 feet.

The details of such fixed equipment as linen closets, serving kitchen cases, etc., should be so constructed as to leave a free space behind all cases. The linen cases should have open shelves, and be so built that they can be removed for cleaning.

Serving kitchen and sink room cases should have slanting tops, so that any dust that may be seen may be readily removed.

The medicine closets for each ward unit, if built into the wall, should have no reëntering angle; should be tiled about the sink and slab; and should have artificial lighting, with shelves of plate glass or metal.

If clothes closets are provided for the private rooms or wards they should be built with the same care that is suggested for the medicine closets. I have found that by placing the vent for the private room in the ceiling of the closet and cutting the bottom of the door 2 inches short, the ventilation of the room as well as of the closet is accomplished.

Elevators

Elevators should be provided where buildings are more than 2 stories in height. Where there are comparatively few to use the elevator the automatic type saves the expense of an operator, and it may be operated with perfect safety by patients or attendants.

In many of the ward units and the nurses' residences of the various departments the automatic elevator could be substituted without any attendant danger.

The details of the elevator should be carried out on hygienic lines, and it should be made of sufficient size to carry a bed with a patient, with plenty of room for nurses and attendants.

The elevators at Sea View and Bellevue have already been criticized; Sea View for having too many, Bellevue for not having enough. A more extended use of the automatic type is suggested.

Equipment

The equipment of the general hospital is fraught with nearly as many perplexities as the planning of the buildings. The question of the best bed, the best food wagon, the best wheel stretcher or operating table, is constantly met. I know of no general rule to apply, except this, that the simpler the lines that will accomplish the purpose, the better the equipment. The requirements of beds alone are legion. A bed should be comfortable for the patient; should be the right height to make the work easy for the nurse; should be on large casters at the head and provided with an adjustable bed truck at the foot; and with extension legs to allow for raising the bed without blocks. If the bars at the head are put in horizontally instead of vertically they serve for mild exercise bars for the patient.

I have found in my own practice that the general dealer in supplies tries to sell the wares he has in stock and is not anxious to have special designs carried out. I have also found that in order to get the best results it is necessary to have special work for special uses. The greater part of the equipment can be standardized, but much improvement can be made on the present standard which is being used.

Grounds

While the wards should be made homelike, with studied artistic effect of wall coloring—the roof ward giving the freshness of out-of-doors—the grounds about the institution should have much study; for in the warmer season many of the patients can be about the grounds. These grounds should be laid out with paths and walks, arbors and shrubbery, with seats and canopies, and an occasional fountain; for the pleasant environment of an institution has its therapeutic effect upon the patients. The green grass and shrubs largely prevent dust from reaching the patients. Comfortable seats and walks keep the patients out of doors; so that the money expended upon the grounds to make for the comfort of the patients hastens convalescence, and therefore saves the institution money in the end.

Conclusions

In this hurried report, I have been able to merely touch on some of the principal points to be considered in the planning for the housing of the sick. To make a comprehensive report of the conditions of all of the buildings which house the 20,000 or more under the charge of the Departments of Charities, Health, and Bellevue and Allied Hospitals would take months.

It would seem, however, that in planning for future enlargement of the hospital system for the City of New York, the islands, and not the mainland, should be considered; and that numerous relief stations should be established in different sections of the City for emergency work, in connection with dispensaries and milk stations.

I wish to acknowledge the courtesy of Dr. Fitzgerald of the Charities Department, and of the Superintendents of City, Metropolitan, and Kings County Hospitals, of Dr. Wilson of the Health Department, and Dr. O'Hanlon of Bellevue Hospital, in accompanying me on my brief inspection of the various buildings.

Respectfully submitted,

EDWARD F. STEVENS.

THE INVESTIGATION

BY

JOHN P. FOX

Methods Used in Figuring Costs

The figures of cost have been obtained, whenever possible, from official sources, from the Comptroller's office, and the records of the different departments. In the case of unfinished buildings, contracts and bids have been used as the basis of estimating costs. The figures of cost of some of the buildings have been obtained from the architects of the buildings.

What the Cost Includes

The figures showing the cost of each building represent the cost of construction and fixed equipment, such equipment as is usually included by architects. Architect's fees are not included as part of the cost.

Cost per Cubic Foot

The most common basis for judging the cost of a building is the cost per cubic foot. This is obtained by dividing the total cost by the number of cubic feet enclosed by the outer surfaces of the building, including all projecting spaces, such as steps, porches, penthouses, etc., but not including purely ornamental projections, like cornices, parapets above the roof, or chimneys.

There is no uniform practice among architects as to including or excluding minor projections when figuring cubic foot costs. Where a building has a number of open porches or balconies, and the air space enclosed by these is included in the cubic contents of a building without any allowance for their lower cost, the result is obviously to reduce the average cost per cubic foot of the building, and if two buildings are compared in cost, one with considerable porch or balcony projection and another with little or none, the former will obviously make the better showing as to cost per cubic foot.

In order to treat all buildings alike and make the cost figures comparable the cubic contents of all projecting spaces have been estimated on a basis of a representative proportion of the cost per cubic foot of the building. For example, where a porch was of wood, with wooden floor and roof, only 25 per cent. of the space enclosed was taken in determining the cost per cubic foot. Where a porch or balcony was of fireproof construction but detached from a building and open on all sides, it was rated at 50 per cent. of its cubic contents. This percentage has been checked up with the actual cost of balcony construction and found to give approximately correct results as to cost. Steps, terraces, and other projections have been similarly treated, so as to give comparable figures on the whole building.

Where a porch or balcony was substantially a part of the main building, of equally heavy construction, and especially where enclosed with windows,

it has been treated as a part of the main building. The same rules have been applied to projections on the roof.

The height of a building has been measured from the under side of the basement floor to the mean height of the roof, whether flat or sloping. Foundations have not been included, because they vary so much in depth and character. Allowance has been made in every case for basement floors excavated to different depths at different points. Indeed, in almost every case, the cubic contents of each floor of a building have been determined separately, instead of taking the mass of a building as a whole.

In getting at the figures for cubic contents the architect's drawings have been used in all cases, except occasionally where the architect's own figures have been used for some minor building, and the measurements of the buildings have been carefully taken, so as to make the results as accurate as possible.

It was hoped to be able to subdivide the cost per cubic foot for each building into the different items which make up the cost, such as foundations, iron and steel, concrete, terra cotta, etc., so as to show where the cost of a building was high or low, and what details of construction chiefly brought about the high or low cost. It was found, however, that the details making up the total costs of buildings could not always be obtained, and that, where available, they were generally prepared by the contractor simply as rough estimates for the purpose of assisting the architect to determine the amount of partial payments due from time to time as the building was being constructed.

Cost per Square Foot

Within certain limitations, the cost of buildings per square foot of floor area has a value. If a building has a large balcony area, and this area is included in the floor area, it reduces the square foot cost, while the omission of all balconies would run up the cost per square foot of buildings having them. The area was taken inclusive of the walls in every case, and included basement area, floor area, and area of balconies, porches, and projections, but only when these were covered. That is, the area of each successive balcony having another floor or roof above was included at each floor level. In the case of roofs, only such areas of a flat roof were taken as were enclosed, and such penthouses as had a substantial roof over them, as in the case of some roof wards and roof gardens.

Comparative Tables

In order to show some of the elements which affect the cost of buildings a series of comparative tables has been prepared, in which recent buildings have been grouped according to types. The groups are composed of: nurses' homes, dormitories, tuberculosis pavilions, and ward buildings. These tables accompany this part of the Report on pages 679 to 682.

In the tables there are given for each building, in addition to various cost figures, some of the principal facts affecting the cost of the building, as well as the service and accommodations, such as the materials used; bed capacity; square feet of floor space per bed; cubic feet of space per bed; areas of different rooms used for different purposes; heights of floors; number of bedrooms and beds in each; data in regard to wards; size of typical rooms or wards; and plumbing fixtures.

Square Feet and Cubic Feet per Bed

Two figures were worked out for each building, which summarize to a considerable extent the relative economy in planning the buildings used for one purpose; viz., square feet of floor area per bed, and the cubic feet of space per bed. The square feet and cubic feet figures were the same as those used in working out the cost for each of these items, including walls, balconies, etc., as already explained.

The square feet per bed shows whether the floor space has been economically used; while the cubic feet per bed adds the element of height. If the floor space is unnecessarily large and the height of floors is unnecessarily great, then the cubic feet of space per bed shows the combined effect of uneconomical planning.

In comparing the homes for nurses the areas devoted to purposes other than bedrooms have been divided by the proposed number of nurses, in order to make a comparative showing of the accommodations for instruction, recreation, etc.

Cost per Bed

The most important figure for comparing the cost of similar buildings is naturally the cost per bed; for the bed is the unit of the hospital. All the elements affecting the cost in a building are combined in this figure.

In estimating the bed capacity of different buildings the original plans have been followed as far as possible; that is, the capacity represents the number of beds actually planned for when the building was built, and not the number of beds found in use to-day. This going back to the original capacity was found necessary in order to make comparisons practicable; for some buildings have had to have more beds placed in them than they were designed for, while others have less beds, the pressure for space not being so great.

Standards for Comparisons

While the different buildings of one type can be compared with each other to determine which are satisfactory and which are not, it seemed better to avoid comparisons as far as possible, especially between buildings of different departments. Instead, standards have been selected for each type of building. These standards represent existing buildings, or buildings in course of erection, or about to be erected, which seemed to be satisfactory and economical; some of these are within and some outside the City.

In making comparisons with the standards the aim has been, not to criticize existing buildings merely for the sake of criticism, but simply to bring out facts of value for planning future buildings.

Nurses' Homes

The Standard

A nurses' home which suggested very satisfactory standards in regard to space and the necessary provisions in a home was found in a city near New York. The building is under construction to-day, and represents the latest ideas in practical hospital planning. It is a fireproof structure, with terra cotta walls and concrete floors and roof, built to accommodate 73 nurses, with provisions for enlargement. The basement is well above ground, and is adapted for dining room, kitchen, and storerooms. An ele-

vator connects all floors with the basement. The first floor has a compact entrance hall, with window seat in alcove; 2 small reception rooms; a large library and lecture room combined, adapted for recreation; and a small tea room for serving refreshments. On each floor is an attractive study or sewing room, with a fireplace at one end. These rooms, used for reception, sitting, and recreation purposes, are termed the general rooms, and the combined floor area devoted to them will serve as one basis of comparison.

The total floor area of these general rooms amounts to 31 square feet per nurse, and the provisions appear to be liberal without being extravagant.

For the teaching of nurses 2 rooms are often provided—a class room and an instruction kitchen. Sometimes the class room work is done in the largest general room of a home; whether it is a library, assembly room or recreation room. In the nurses' home used as a basis for a standard part of the library is used for class room work, affording an area of about 5 square feet per nurse. If desirable to have a separate room, 5 square feet per nurse appears to be sufficient, and, also, 5 square feet, or even less, for an instruction kitchen. For ordinary teaching purposes, then, 10 square feet per nurse would appear sufficient. If teaching is done in the library, the total area for general rooms could be reduced by 5 square feet to 26 square feet per nurse.

A comfortable but compact dining room requires from 16 to 18 square feet of floor area per person seated. It is hardly necessary, however, to provide enough room for every nurse to be seated at the same time, for such is contrary to practice. As a reasonable allowance it has been suggested that provision be made for one-half of the nurses at one time, plus an additional allowance of 25 per cent. This would require 62½ per cent. of 18 feet, or 11 square feet per nurse. If other nurses than those living in the building are to be served in the dining room of the home additional space will be required.

Kitchens vary greatly in size, but a generous allowance would be 18 square feet per nurse, though in some nurses' homes about half of this area has been found to be sufficient. This allowance would include pantry, serving room, help's dining room, and storage space immediately adjoining the kitchen.

Each nurse has a single room in the standard home, a provision which is now considered a necessity. There is also in each room a closet, lighted by a window, and a set basin, with hot and cold water. Each room, including the closet, is 8 feet 6 inches by 13 feet, which has been found large enough, though a minimum size of 8 feet by 12 feet is sometimes used. Each room has 110 square feet of floor area, including the closet. With a ceiling height of 8 feet 6 inches, which appears ample, the room contains 935 cubic feet.

The bathing facilities consist of 3 tubs and 1 shower on each floor, or 1 to every 6 nurses. There is also 1 water closet to every 6 nurses.

There are 2 substantial airing balconies on each end of the building, and the flat roof is covered in the center with a shelter large enough to allow the nurses to sleep out of doors. Such a flat roof is very desirable, and is decidedly preferable to a sloping roof. It permits rooms on the upper floor unrestricted in size, shape, light, and air, as well as the use of the roof for airing or sleeping purposes.

On the upper floor is an infirmary with 4 patients' rooms, a diet kitchen, sink room, toilet, and linen cupboard, with a total floor area, including corridor, amounting to 11 square feet per nurse.

For heights of rooms, 8 feet 6 inches seems ample for bedrooms. Concrete floors are now constructed with a thickness of 12 inches, so that a height from floor to floor of 9 feet 6 inches is practicable. For kitchen, dining room, and general rooms, a greater height is desirable; but it seems hardly necessary to have the average floor height exceed 10 feet.

Between the ceiling of the upper floor and the roof considerable waste space is often found, due to the desire of the architect to get an impressive exterior design. An attractive building can be obtained without such sacrifice of economy, but a certain amount of space at this point can well be used for ventilating ducts. In the nurses' home which serves as a standard the space between the ceiling of the upper floor and the roof is 2 feet 6 inches.

The floor area of the building, including the airing balconies and the covered roof garden, amounts to 420 square feet per nurse. The cubic space of the building is 4,280 cubic feet per nurse.

As to cost, the Department of Public Charities has had two nurses' homes built recently for 29 and 31 cents a cubic foot, respectively, the latter being on Randall's Island, a place difficult of access. The same Department is getting similar buildings constructed for even a lower figure. So that 30 cents per cubic foot, which is the cost figure of this building adopted as a standard, appears reasonable. There may be reasons why it should be exceeded in the future, such as increases in prices of materials and labor, expensive foundations, and remote sites, but allowance can be made for such factors in determining whether or not the cost of a proposed nurses' home is reasonable.

With a cost of 30 cents per cubic foot, and an allowance of 4,280 cubic feet per nurse, the cost per nurse would be $1,284; and with an allowance of 420 square feet of building per nurse, the cost per square foot would be $3.06.

Nurses' Home, Riverside Hospital
Department of Health

This is next to having been the least expensive of the nurses' homes studied, the cost per nurse having been $1,643, compared with the standard cost of $1,284 per nurse, or about 28 per cent. more. The figures for the building include both the original building, begun in 1903, and the addition which is now nearing completion.

The excess of the cost above that of the standard can be explained in several ways. The bids were high for the original building, the cost per cubic foot having been 39 cents, compared with 33 cents for the addition. Making allowance for the location of the building, the latter figure of 33 cents corresponds exactly with the standard cost of 30 cents. The architect has found that construction on North Brother Island costs about 10 per cent. more than on the mainland, because all the workmen and materials have to be transported across the water. Were it not for the fact that the high cost of the original building naturally tends to offset the low cost of the addition the cost would be very near that of the standard.

In the allowance of area per bed, in the building as a whole, 443 square feet is only slightly above the standard of 420 square feet. The area for general rooms is considerably below that in the standard, 26 square feet in this building, compared with 41 square feet in the latter, while the dining room and the kitchen allowances are much less. The height of the floors,

10 feet 2 inches, is a little greater than needed, and the nurses' rooms are slightly larger than really necessary, these two items causing the excess of space over that in the standard. Each nurse has a room to herself.

The toilet facilities, except in the number of water closets, are less than those of the standard, there being no set basins in the bedrooms. This would tend to reduce the cost of the building.

Nurses' Home, Kingston Avenue Hospital
Department of Health

In the matter of the cost per nurse this was the least expensive of all the nurses' homes studied, the cost having been $1,190 per bed, compared with the standard of $1,284, or about 7 per cent. less. Two-thirds of this building was built in 1904 and the remainder 2 years later, but in this case the addition was more expensive than the original building, the original having cost 32 cents per cubic foot, compared with 40 cents for the addition.

The allowance of general rooms per nurse is about the same as that in the standard, but the dining room area is only about 62 per cent. of that in the standard. The kitchen allowance per nurse is about 44 per cent. of that in the standard.

The height of floors is slightly greater than in the standard, but this tendency toward increased space is more than offset by other elements. Probably the chief factor in lowering the space allowance is the provision for 2 nurses in a room in 32 per cent. of the rooms, the building as planned having 47 single rooms and 22 so-called double rooms. And while the single bedrooms are ample in size, in fact slightly larger than in the standard, the pairing of the occupants of the double rooms causes this home to have a much smaller allowance of space per bed than any of the other homes compared, the square foot area in this home being 3,450, as compared with 4,280 in the standard. However, it is true that some of the other homes have none but singly occupied rooms, and none have so large a percentage of double rooms.

The toilet facilities, with no set basins in any of the bedrooms, are fewer than in the standard, and, as a whole, less than in any other home studied. The low cost per nurse was due to the insufficient number of toilet facilities and also the housing of 2 nurses in a room in a large percentage of the rooms.

Nurses' Home, Metropolitan Hospital
Department of Public Charities

Judged by the cost per bed this was the most expensive home studied, having been $2,157 per bed, as compared with the standard of $1,284, an excess of about 68 per cent. In arriving at these figures, and also the allowance of space in the different parts of the building, the number of help sleeping in the attic was included in the calculation.

In getting at the reasons for the high cost of this home the first thing noticed was the high cost per cubic foot, about 40 cents. This may be partly accounted for by the remoteness of the site, which is on the extreme north end of Blackwell's Island, although other stone buildings in the same hospital group have cost but 31 and 32 cents per cubic foot.

As found to-day, the allowance of area per nurse or per bed in all the rooms is more than that in the standard, the kitchen alone excepted. This will be partly equalized if the building be enlarged to accommodate more nurses. It would have been more economical to have so planned the building that the common rooms would have been in proper proportion to the nurses actually provided for, with plans for enlargement of the common rooms if wings were subsequently added.

The floor area per nurse, 523 square feet, is much larger than in either of the other homes mentioned, and is about 25 per cent. larger than in the standard. The height of the floors is exceeded only by that in one other home, which, with the exceptionally large entrance hall, the library, and sitting rooms on 3 floors account for the larger allowance of floor space in this Home. The lecture room and instruction room are generous in size.

This building provides 5,430 cubic feet per nurse, as compared with 4,280 in the standard. Single rooms, considerably larger than in the standard, have been provided for the nurses, but they contain no wash basins, and those provided in the general toilet rooms are at the rate of 1 basin to every 3½ beds. The standard provides a basin in every room. The general toilet facilities are about the same as in the standard.

Nurses' Home and Help Quarters, Sea View Hospital Department of Public Charities

The cost per bed of this building was exceeded by that of but one other among the homes studied, and was about 42 per cent. higher than that of the standard. The cost per cubic foot, about 45 cents, is a very high figure, but a somewhat higher cost is to be expected at a site so remote from transportation lines.

The general capacity is rated at 4,050 cubic feet per bed, as compared with 4,280 cubic feet in the standard. This small space allowance is secured by a sacrifice of general rooms and an excess space in the bedrooms. For the nurses' general rooms there is a reception room, a writing room, and a large recreation room, all on the ground floor. There is no large reception hall, as at Metropolitan Hospital, and no sitting rooms on the other floors. The teaching rooms consist of a class room and teaching kitchen. The dining room is a little larger than in the standard, seating about 75 per cent. of the nurses at one time.

The kitchen space is just a little more than that in the standard, while the infirmary space is exactly the same. The height of the floors is moderate, though a little higher than in the standard, except in the attic, where it is the same as that in the standard.

The single nurses' rooms, which comprise 100 of the 107 nurses' rooms, are much larger in area than in the standard, although narrower and longer. But the extra space in the rooms is offset by unusually narrow corridors.

The compactness of the help's quarters probably also contributes in bringing the square foot area and cubic foot space per bed below that in the standard. The help sleep in 16 single rooms or cubicles in the attic, only 5 of which have outside windows. The remaining 11 are lighted by skylights in the roof, the partitions reaching to about 13 inches below the ceiling. The largest room shown on the plans has an area of about 98 square feet of floor space; the next largest room has 63 square feet; and 7 rooms have an area of only 59½ square feet.

The toilet facilities for the nurses seem to be sufficient, except perhaps on the attic floor. There are 9 bathtubs and 6 showers in the general toilet rooms for the nurses. These, taken together, are slightly less than in the suggested standard; but there are more water closets than in the standard, and any lack of tubs and showers is offset by the furnishing of a set basin in every nurse's room.

Nurses' Home, Kings County Hospital
Department of Public Charities

The cost per bed of this Home was about 36 per cent. more than that of the standard, due to a liberal allowance of space in a number of ways. The square foot allowance of area per bed is not so much in excess of that in the standard as is the cubic feet of space per bed, which is the largest of any of the homes, due to a greater height of floors than in any of the other homes compared.

The cost per cubic foot, 29 cents, was lower than that of any of the other homes. From this, one might expect a cheaply planned and constructed building; but on inspection quite the opposite appeared to be the case. The building is very handsome inside; in good condition; and no poor construction is noticeable.

The number and size of the general rooms, as well as the considerable height of the floors already mentioned, are probably the chief causes for the high cost per bed of the building. On the first floor there are a large entrance hall, 2 reception rooms, and a large library, with a sitting room on each of the 3 bedroom floors above; while the fifth floor has another very handsome, domed sitting room, with a large gymnasium. The floor area of all these rooms now amounts to about 54 square feet per nurse, but when two wings are added to the building, as provided in the plans, this area of general rooms will be reduced to about 35 square feet per nurse, which, however, will be 4 square feet more than in the standard.

The area of the teaching rooms is very large, and, with the wings added, will still be more than that in the standard. There are 3 teaching rooms on the first floor, called demonstration class, study class, and lecture rooms. The area of the dining room at present exceeds that in the standard, but its proportion to the whole will be less when the wings are added. The kitchen and serving room area is now less than in the standard, and the infirmary, though at present larger, will be the same as that in the standard when the building is extended.

The floors have the greatest height of any of the homes, the first floor being over 15 feet high and the fourth floor 14 feet in height. The heights are evidently due to a desire for architectural effect, especially in the exterior of the building. This extra height accounts, in a large measure, for the high cost per nurse, $1,747, as compared with $1,284 for the standard.

The nurses' and help's rooms are all single. The smallest of the nurses' rooms have the least square feet of area of any compared, but almost equal that of the standard, and are large enough. The closets are arranged between every 2 rooms, instead of at the end nearest the door, an arrangement which uses more building space than the end closets.

The number of bathtubs, showers, and water closets is larger than the standard, and there is a set basin in every nurse's bedroom, the same as in the standard home.

Nurses' Home, Children's Hospitals, Randall's Island
Department of Public Charities

This building has about the same square foot area and cubic foot space allowance per bed as the Nurses' Home of Metropolitan Hospital. The cost per bed was about 34 per cent. higher than that of the standard, while the cost per cubic foot of 30½ cents was close to the standard of 30 cents, and very low, considering the inaccessible location on Randall's Island.

The floor areas of the different kinds of rooms per nurse or per bed are, in some cases, close to those in the standard, and in other cases greatly exceed it. The teaching and infirmary areas are more than double those in the standard. The general rooms and kitchen nearly equal those in the standard; while the dining room is 64 per cent. larger.

When the Home is increased to its full size the dining room space will be exactly the same as in the standard; that of the general rooms and kitchens less; but the teaching and infirmary space will still be considerably in excess. It is well to repeat here the statement that when possible the common rooms should be adjusted to the number of nurses provided for, and the building so planned that these common rooms can be enlarged with any increase in the number of rooms for nurses. The unnecessarily large common rooms add to the original cost of the building, the subsequent upkeep, and lessen the bed capacity.

The height of the lower floors, though exceeded in only two other buildings, is greater than in the standard. The nurses' rooms, with closets between, use more space than necessary, though this is offset by the arrangement of 4 rooms for 2 nurses each. Two of the help's rooms also provide for 2 tenants in each. The rooms for the latter have the closets at the inside end, with the most economical arrangement of space.

Nurses' Home, Fordham Hospital
Bellevue and Allied Hospitals

The cost of this building could not be determined from the figures obtained, for only the cost of the entire Hospital was found. The cubic feet of space per nurse is moderately excessive, being about 13 per cent. more than in the standard.

The floor areas of the different groups of rooms were found to very nearly coincide with those in the standard, except for the general rooms, which are about 26 per cent. larger. These include a large library, reception room, and 1 sitting room for the 4 floors. The height of floors is moderate, though not as low as in the standard.

The somewhat square shape and considerable depth of the building do not lend themselves to an economical size of bedrooms, the smallest of which has the largest area of any of the minimum sized nurses' rooms in the homes compared. Six of the bedrooms were designed for 2 beds and 1 for 3 beds.

The toilet facilities are ample, except that there are no set basins in the bedrooms, though there is 1 for every 3 nurses in the toilet rooms, but otherwise they equal those in the standard.

Nurses' Home, Greenpoint Hospital
Department of Public Charities

This building has been planned but not yet built, so that the cost figures are not obtainable. However, the main building of the Hospital now under construction is costing only 26½ cents per cubic foot.

This Home differs radically from those already considered, in that it contains only bedrooms and sitting rooms; the cooking being done in the main kitchen of the Hospital, where the assembly, class, and dining rooms are located. The allowances of floor area for the general, teaching, and dining rooms are very large, compared with those in the standard. For general and teaching purposes, taken together, the floor area is almost double that in the standard home, and the dining room area is exactly double that in the standard.

The height of ceiling in all the bedrooms is 10 feet 6 inches, instead of an average of 9 feet and a minimum of 8 feet 6 inches as suggested in the standard. The area of the bedrooms is slightly above that of the rooms in the standard, though their cubic feet of space is much more, owing to the high ceilings. The toilet accommodations are fewer than those of the standard in the matter of baths; more in the number of water closets, and identical in the matter of wash basins.

Dormitories

The Standard

There is a wide divergence of views as to how dormitories for help should be constructed. Some authorities maintain that it is not only unnecessary to provide single rooms for the help, but that it is wiser not to do so, at least with certain grades of employees. Others would give the help not only single rooms, but practically the same accommodations as are provided for nurses, in the way of bed, reception, and sitting rooms, and toilet facilities.

In deciding upon a standard dormitory to show the proper space per bed, the size of the rooms, the toilet facilities, and other requirements, a mean was taken between the two extremes shown in the table and moderate sized rooms with moderate accompaniments were selected. A 5-story building, providing for 38 beds on a floor, was planned; with the smallest satisfactory single bedrooms and also with the largest necessary rooms, and a mean was taken between the two.

For a standard bedroom, 8 feet by 12 feet, giving a floor area of 96 square feet, seems large enough, this being generally regarded as the minimum satisfactory size for a nurse's room. A ceiling height of 8 feet 6 inches seems sufficient, or 9 feet 6 inches from floor to floor, giving 816 cubic feet of space in a room of the dimensions stated, including a closet. Toilet facilities should provide a bathtub or shower for every 8 beds; a water closet for every 6 beds; and a hand basin for every 4 beds.

For reception, sitting, and recreation rooms, an allowance of 10 square feet of floor area per bed seems sufficient, or about one-third of the requirement for nurses, for when help are given rooms to themselves it seems hardly necessary to furnish so much space for general purposes as when 2 or more sleep in a room. Some provision for sitting out of doors is desirable; on porches, the roof, or both. Recreation rooms can well be placed

in the basement, where ample space is generally available and quite satisfactory for night use.

The area and cubic space of building, over the walls, needed for these purposes are about 200 square feet per bed and 2,000 cubic feet per bed, respectively. For a standard cost, 30 cents per cubic foot has been used, the same as for a nurses' home, this being 2½ cents above the minimum cost of the dormitories compared, and about ½ cent lower than the Nurses' Home on Randall's Island. A dormitory should not be so elaborately finished nor contain so many rooms for general purposes as a nurses' home, but, having smaller rooms, it would be more compact, and so, while a somewhat similar cost per cubic foot could be expected, the cost per bed would be much lower. The resulting cost, over the walls, would be $600 per bed and $3 per square foot.

Maids' Dormitory, Willard Parker Hospital
Department of Health

This building has been planned but not yet built. It will be 5 stories high, with the first floor occupied by an infirmary for sick maids, matron's quarters, and temporary rooms for internes. The other floors will each have 2 open dormitory rooms, with 38 beds to a floor, a sitting room, large toilet room, and linen room. The dormitory rooms will eventually be divided by steel partitions into spaces for 2 beds each, with closets at the head of each bed.

As no contracts have been awarded for this building the exact cost cannot be stated. When the last bids were received the lowest combined bid for construction, heating, and plumbing was $103,227, and these figures have been considered as representing the cost. This is at the rate of $633 per bed; $3.33 a square foot; and 27½ cents a cubic foot. While the cost per bed is slightly above that of the standard, it would be lower if the first floor were used for dormitory rooms and not for the infirmary, internes, etc. The space per bed would then be 1,975 cubic feet, or practically the standard of 2,000 cubic feet.

This is interesting because it shows that there is no economy of space in putting several or even 20 beds in a room, as was planned in this case. The open dormitory building may be somewhat cheaper than the type with single rooms, because of the absence of so many partitions and doors, but there is little saving in space.

The sitting room area in this building is exactly that in the standard, but the toilet facilities are less. The height of the floors is much greater than necessary, furnishing in the open dormitory rooms about as much air space as some authorities consider necessary in an acute hospital ward. These high floors add considerably to the cost of the building.

Maids' Dormitory, Riverside Hospital
Department of Health

This building has not been built nor any contracts awarded, but the lowest bids received amount to $95,340, or $3.83 a square foot and 30 cents per cubic foot. Like the Maids' Dormitory of Willard Parker Hospital, it will have the first floor devoted to an infirmary for sick maids, matron's quarters, and rooms for internes. The other floors will have 2

open dormitory rooms, containing 32 beds to a floor; the space eventually to be divided off by steel partitions into cubicles for 2 beds each, with closets at the head of each bed.

If the first floor of this building would have 32 beds like the others, the cost per bed would be reduced to $745, and the square foot area per bed to 195 square feet, with 2,480 cubic feet of space per bed. This last is greater than in the standard, though single rooms are not provided.

The area of sitting rooms is a little more than that in the standard; bathing facilities a little less; with water closets and wash basins just equal to those in the standard.

The space between floors is unnecessarily high, this being one of the reasons for the excessive cubic contents per bed in spite of the arrangement of 16 beds in a room.

The higher probable cost per cubic foot for this Dormitory than that of Willard Parker Hospital may be due to the remoter location, on North Brother Island, the difference in cost between the two buildings being 12 per cent, or almost exactly the increase in price for North Brother Island found by the architect of previous buildings there.

Dormitory for Female Help, Metropolitan Hospital
Department of Public Charities

This building is used wholly for dormitory purposes, containing 91 bedrooms, of which 83 are single rooms and 8 are double rooms. It is a very commodious building, almost as much so as a nurses' home, and as a result the square foot area of building per bed is 70 per cent. more than in the standard, while the cubic foot space per bed is 84 per cent. more. The cost per bed was twice that of the standard.

The first floor has a large reception hall, with open fireplace; matron's suite; 17 bedrooms; 2 toilets; 2 wash rooms; a special laundry closet with set tub; sink and storage closets. The floors above have 22 bedrooms each, and toilet and wash rooms. There is also a large sitting room on every floor.

The sitting room area is slightly less than in the standard, and the toilet facilities are fewer, except wash basins, which are the same as in the standard. The height of the floors is less than in the Riverside buildings, but greater than in the standard. It will be noticed in the table that there is a space of from 3 to 4 feet between the highest ceiling and the roof. Besides this, the walls rise 3 feet 6 inches above the roof, or, on the average, 7 feet above the ceiling of the fourth floor. This, of course, was responsible for some of the higher cost of this building.

The size of the smallest rooms exceeds slightly that in the standard, the rooms as a rule being large enough for nurses' rooms.

Dormitory for Female Help, City Hospital
Department of Public Charities

This building, which is under construction, consists principally of single bedrooms, with a large sitting room on each floor. The square foot area of building per bed is 75 per cent. more than in the standard and the cubic foot space per bed is about 80 per cent. more, the resulting cost per bed being about 90 per cent. more than that of the standard. One reason for this is

the large size of the 3 sitting rooms, each equal to 3 bedrooms, amounting in floor area to 20 square feet per bed, or double that in the standard. The toilet facilities are about the same as in the standard.

The height of the floors is lower than that of any other dormitory compared, but still seems higher than really needed. There is no waste space, however, between the ceiling of the upper floor and the roof.

The bedrooms are moderate in size, with just a little more floor area than in the standard.

Male Help Building, Greenpoint Hospital
Department of Public Charities

This Dormitory has been planned but not built, and no figures are available as to its probable cost. The Male Help Building, Female Help Building, and Nurses' Home at this Hospital are alike as to size of rooms, height of floors, toilet accommodations, etc.

The square foot area per bed of the Male Help Building is about 64 per cent. more than in the standard, and the cubic foot space per bed about 106 per cent. more. This last figure will mean a high cost per bed, probably at least double that of the standard. The greater excess of the cubic feet per bed over the square feet per bed is due partly to the height of the floors, but chiefly, no doubt, to a sloping tile roof, the top of which is 12 feet 6 inches above the highest ceiling.

The sitting room space is just a little less than in the standard. The toilet facilities also are less, except the wash basins, of which there is 1 in every room. The bedrooms are all single and of large size.

Male Dormitory, Bellevue Hospital
Bellevue and Allied Hospitals

This building is part of the Pathological Building, and, therefore, its cost could not be separated or carefully determined. But as the structure itself is about the same as the Pathological Building the cost per cubic foot for the whole building has been assumed for the Dormitory.

Accommodations were planned for 246 beds on 6 floors, in rooms with from 2 to 5 beds each, but as the building is not yet full some of the higher grade of help, such as clerks, use the smaller rooms singly.

The cost per bed of this Dormitory was nearly double that of the standard. This was partly due to the high cost per cubic foot of 41 cents.

The high cost per cubic foot was due to the building's expensive construction and finish. It is a high structure and required the expense of a steel frame.

The square foot area per bed is less than that in the standard, but the cubic foot space per bed is nearly 50 per cent. more than in the standard. The sitting room space is very large, nearly double that in the standard. In the sub-basement there is a bowling alley, which is not included in the space as figured, and in the basement there is a library, smoking room, and billiard room, and on the roof there are 2 sitting rooms.

The toilet facilities are all much less than in the standard. The height of floors, which is the same as in all the new Bellevue buildings, is especially great for a dormitory, with 1 story of 19 feet 8 inches, and the others

15 feet or more. This explains why the cubic foot space per bed is so much in excess of that in the standard.

The size of the smallest room on each floor, designed for 2 beds, is 8 feet by 18 feet, with an actual floor area of 125 square feet, or 73 square feet per bed, compared with the 96 square feet in the standard. The rooms for 3 beds are about 12 feet by 18 feet, with 72 square feet per bed. With a 13-foot ceiling, the air space amounts to 946 cubic feet per bed, but the higher space is not counted as of value.

Ward Buildings

The Standard

There is no type of building for which it is more difficult to fix a standard than a ward building; because of the constant improvements in plan found desirable by medical men, or required by different conditions and services. A tentative standard building has been designed, however, to serve as a criterion by which to form some judgment as to the economy of the planning and cost of existing ward buildings.

In the standard set forth in the table an allowance of 1,200 cubic feet per bed was fixed for the wards, with 100 square feet of floor per bed, and a ceiling height of 12 feet. Large wards, containing 32 beds, were adopted in order to get economy of space, while the requirements of smaller ward units were met by dividing the wards off by screens into 4 units of 8 beds each. A large airing balcony was provided, and toilets and utility sinks placed at the end of each ward.

The administration end of the building was planned to contain: a large ward kitchen; large utility room; patients' toilet room; day room; linen room; bathroom, large enough to wheel a patient into; a room for surgical dressings or other purposes; elevator and stairway; and 3 quiet rooms, containing 5 beds in all. The flat roof would have the same administration rooms as the other floors, with the ward space properly open to the air.

The basement was designed to be 9 feet in height up to the first floor, with the floors above 13 feet in height, providing a 12-foot ceiling.

The resulting square foot area per bed of the building worked out at 236 square feet, with 3,008 cubic feet of space per bed.

The same cost per cubic foot was taken as for dormitory buildings; viz., 30 cents. This may seem low for a ward building, but two such buildings have recently been built in Brooklyn at a cost of about 28½ cents per cubic foot.

Measles Pavilion, Willard Parker Hospital
Department of Health

This is a 7-story, reinforced concrete building, for the open air treatment of measles. There are 22 rooms for observation purposes on the first floor, each with its own toilet and basin, and outside door opening on to a porch. The floors above have 2 wards each, subdivided down the center by a glazed partition, with sections to be opened for cross ventilation, except when mixed infection occurs. The wards are still further divided by glass partitions into stalls for 2 beds each. The service rooms on the ward floors consist of 4 toilets, opening out of each half ward; a kitchen; treatment room; 3 nurses' rooms; a cleaner's closet; and a linen closet. On the center of

each floor there is a large day room and on the upper floor there are operating rooms. There are no separate utility rooms in connection with the wards, all the necessary work being done in the toilet rooms. A large open porch is provided at each end of the building, opening out of the 4 ward divisions, each porch containing an enclosed fire escape.

It may be judged from this description that this was an expensive building; due in a measure to the large amount of subdividing and plumbing required for the proper treatment of a contagious disease. Another reason for the high cost per cubic foot is that the location close to the East River required rather an expensive foundation, this having been responsible for about 10 per cent. of the cost. A third feature that increased the cost somewhat was the use of tiles for floors throughout the building, including the wards, which also is considered necessary in a contagious disease building, and which in this case formed about 5 per cent. of the cost.

The cost per cubic foot of the building would probably have been much higher had it not been built of reinforced concrete, as it was estimated that a brick building would cost about 12 per cent. more than concrete. The conditions for concrete construction were very favorable; with plenty of ground to work on and a simple architectural design, requiring only simple forms.

The cost per bed of the building was considerably lower than that of the standard, and would have been still more so but for the higher cost per cubic foot. There are a number of reasons for this low cost. As many of the patients will be children placed in cribs, a smaller allowance of space per bed was made than would be provided if all the patients were to be adults. The intention to keep the windows open for open air treatment made a lesser air space practicable and, as a result, the square feet of floor area per bed in the wards is about 28 per cent. less than in the standard and the cubic feet per bed 34 per cent. less. This also causes a low figure for the square foot area and cubic foot space of building per bed.

It will be noticed that the floor heights are unusually low for a hospital, being 12 feet, with an 11-foot height to the ceiling. The building is extremely compact in every way, the distance between the ceiling of the upper floor and the roof being only 12 inches, compared with a maximum of 6 feet 6 inches observed at Bellevue.

In order to compare the different ward buildings on a per bed basis; viz., to compare the cost per bed, square foot area per bed, and cubic foot space per bed, it was necessary to rate the capacity of each building in beds on the same basis. This was done by determining the number of beds possible in each building if 1,200 cubic feet of air space were required for each bed. Using this as a basis, the number of beds in the wards of the Measles Pavilion would be reduced from 24, as planned, to 14, the result being to make the cost and other figures per bed higher than those of the standard.

The Department of Health may be criticized for providing such a small floor area and air space per bed; and doubtless there will be times during the winter, with the wards full, when severely stormy or cold weather will interfere with the open air idea and necessitate closing the windows. But, except at such times, the small allowance of space per bed may be satisfactory. With the great fluctuations in the daily census of the Department of Health hospitals, the officials certainly have a problem to avoid having buildings larger than requirements demand during much of the year. The open air treatment permits great economy of space and the results of its working should be watched with great interest.

Isolation Pavilion, Kingston Avenue Hospital
Department of Health

This is a 2-story brick building for the isolation and observation of suspicious contagious cases. The floors are of concrete and also the flat roof. The first floor is much like that of the Measles Pavilion at Willard Parker Hospital, with 20 self-contained observation rooms along a central corridor; administration rooms in the center of the building; and a porch surrounding the building, upon which each isolation room opens by a door. There is no stairway inside the building to the second story.

The second floor has 2 large wards, 44 feet by 30 feet, with administration rooms in the center, consisting of kitchen, nurses' room, bathrooms, lavatories, and storeroom. At each end of the wards is a treatment room, and a room for admission and discharge, with bath. The second story is reached only by stairways at each end of the building, connected with completely enclosed porches. The wards will hold 36 cribs each if arranged in 4 rows with 2 down the center. The floors are moderate in height, the first floor having an 11-foot ceiling and the second a 12-foot ceiling, the same as in the standard.

The cost of this building per cubic foot, though 11 per cent. more than that of the standard, is considerably less than that of the Measles Pavilion at Willard Parker, largely for two reasons: the foundations were simple compared with those of the Measles Pavilion; and the contractor is said to have made a mistake in estimating. The finish of the building is more expensive than in the Measles Pavilion. Marble has been used for the floor base, all the floors are tile, and all the woodwork is metal covered. Considering that the building was built of brick instead of concrete and that the finish is of such an expensive character, it would seem that the cost was low.

The cost per bed was the lowest of all ward buildings studied, the reason being very clear on looking at the square foot area and cubic foot space per bed in the wards; namely, 37 square feet and 438 cubic feet, or only a little over a third of the space in the standard. The capacity of the wards is based on the number of cribs they can hold, not beds. The number of beds possible would be only half the number of cribs, or even less.

The bed capacity of the wards, allowing 1,200 cubic feet per bed, is 13 beds, instead of 36 cribs. This raises all the figures of cost and space per bed, the cost being about 50 per cent. more than that of the standard.

Pavilions A and B, Bellevue Hospital
Bellevue and Allied Hospitals

The first ward building of the new Bellevue buildings is a brick and steel structure, with steel and concrete floor, 7 stories high. The first floor was originally designed for 5 small children's wards and 1 large medical ward, with about 17 other rooms mostly for administrative purposes. The three sides of the building form a court enclosed on the fourth side by a loggia, and balconies have been added on each side of each ward wing. The 6 floors above the first have 2 large wards each, holding 24 beds each, and 17 or 18 other rooms, such as a convalescent ward, quiet rooms, and the usual utility rooms, toilets, kitchens, bathrooms, linen rooms, etc. The number of beds on each floor as planned is 56 or 57. A teaching room was also planned for each floor, with coat room and laboratory in connection

with it, and roof wards have been added since the building was built. One stairway and one elevator serve the entire building.

The floor heights are about the same as in all of the new Bellevue buildings, the only variations being in the heights of the cellar and roof structures. The ground floor is 15 feet high; the next floor is 18 feet 6 inches; the next 15 feet 8 inches; and the floors above 15 feet. The height of ceilings ranges from about 13 feet to 15 feet 9 inches. Between the ceiling of the upper floor and the level of the flat roof is a space of about 6 feet 6 inches.

The cost per cubic foot of this building was the highest of all ward buildings compared. There are many reasons for this: the foundations were of a very expensive character, the building being directly on the edge of the East River; the steel frame and concrete were more expensive than reinforced concrete would have been; and the finish of the building was expensive, the woodwork being heavy and much of the trim unnecessary; and the corridors and various utility rooms have expensive tile floors and tile base.

The cost per bed of the building was more than double that of the standard. The high cost per cubic foot accounts for part of the difference, and the rest of the excess is due to the large amount of floor area and air space provided per bed. In the lowest wards there are 117 square feet of area and 1,523 cubic feet of air space per bed, and in the highest wards the air space is 1,850 cubic feet per bed.

If more beds were placed in the wards and advantage taken of the large air space, the cost per bed could be materially reduced. Allowing 1,200 cubic feet of space per bed the wards would hold 30 beds instead of 24, and the total capacity of the building would be increased 25 per cent. The cost per bed would also be reduced 17½ per cent.

Pavilions L and M, Bellevue Hospital
Bellevue and Allied Hospitals

The second ward building of the new Bellevue buildings is the same as the first; as to construction, materials, and general dimensions. The floor plans are about the same in the provision for wards, but the arrangement of the other rooms has been greatly changed and improved under Dr. Goldwater's direction. The balconies and roof wards have been included in the original construction.

From the point of view of cost Pavilions L and M make a better showing than A and B. The cost per cubic foot is about 12 per cent. less, though it is still 23 per cent. more than that of the standard; the expensive foundations account for 19 per cent. of this excess. The finish of the buildings is not materially different; the same kind of heavy wooden trim has been put in and also tile floors, though in the wards plastic linoleum has been laid instead of wood as in A and B.

While the cost per cubic foot is 12 per cent. less than in the other pavilions, the cost per bed is only 7 per cent. less. Pavilions L and M are slightly larger than A and B and the number of beds planned for has been increased to 2 more in each ward, making a maximum increase of 6 on a floor.

If 1,200 cubic feet were allowed for each bed the wards would each hold 30 beds instead of 26 as planned, making an increase of 56 beds in the building. This would reduce the cost per bed considerably, but this cost

would be almost the same as for A and B; for if space in A and B were wholly utilized the higher cost per cubic foot as compared with L and M would be almost entirely neutralized by the greater square foot area and cubic foot space per bed of L and M.

New Ward Wing, Harlem Hospital
Bellevue and Allied Hospitals

The new ward wing of Harlem Hospital has been planned for some time, but construction was delayed because the first bids received exceeded the amount appropriated. However, more money was appropriated and new bids received, the lowest estimate being less than the lowest of the first bids and well within the appropriation.

The new wing is a brick building, 5 stories high, similar to the main hospital building, and follows the lines of the original structure. It is rather a complicated building in plan, with a considerable number of rooms for special purposes and the basement fully utilized, so that the cost of 34 cents per cubic foot may not in reality be high. The number of beds is not as large as it would be in an ordinary ward building, which helps to account for the high cost per bed, which is more than double that of the standard. The small number of beds accounts for the large square foot area and cubic foot space of building per bed.

One feature that increased the cost unnecessarily is the height of the floors, generally 15 feet, or 2 feet more than in the standard.

New Ward Wing, Kings County Hospital
Department of Public Charities

This is a 4-story brick building, containing 2 large wards on each floor and administration rooms in the center. There are a kitchen and 1 utility room for both wards on a floor, and 1 toilet for each ward. There are 2 quiet rooms with 3 beds in each and the wards have 22 beds each, or, in all, 50 beds on a floor. In an angle between the 2 wards on 3 floors there is an enclosed solarium, with doorways opening into a fire tower, and at the west end of the building there are balconies for every floor. The roof has no provision as yet for a roof ward.

The cost per bed of this building was lower than that of any other ward building studied, and 5 per cent. lower than that of the standard, due to the fact that the cost per cubic foot was 5 per cent. lower. The cubic foot space of building per bed is exactly that of the standard, while the square foot area per bed is 5 per cent. less.

The height of the floors is slightly more than in the standard, but the building as a whole appears very satisfactory as to cost.

Children's Hospital, Kings County Hospital
Department of Public Charities

This is a 4-story brick building, comprising the center and east wing of the completed structure. The center pavilion contains small wards with windows on three sides, while the east wing has larger wards with windows on four sides. Every ward opens onto a balcony. The roof has a play-

room in the center, but the rest of it is uncovered. The utility and toilet facilities are in 1 room.

The cost of this building per cubic foot was nearly the same as the new ward wing at the same hospital, and 4 per cent. below that of the standard. The square foot area per bed is less than in the standard, but the cubic foot space is more, due to the floors being higher than in the standard. The resulting cost per bed is 1½ per cent. more than that of the standard.

Tuberculosis Pavilions

Standards

It was found necessary to arrange standards for two types of buildings for the treatment of tuberculosis; for the incipient and advanced stages, respectively. The four buildings at North Brother Island for open air treatment were classed as of the former type, and the East and West Infirmaries at Metropolitan Hospital and the ward buildings at Sea View were grouped as being of the advanced stage type. No study has been made of the buildings for the treatment of incipient cases at Otisville, because of lack of time.

Standard Building for Open Air Treatment

No building as yet erected for the open air treatment of tuberculosis seems wholly satisfactory and so a new standard was devised, combining the best features of existing and proposed buildings. Four buildings with varying amounts of space were designed and the one which provided sufficient space and accommodations, without appearing extravagant, was selected as the standard. The structure was planned to be 4 stories high, with 40 beds on a floor, or 160 beds in all. The administration rooms would be in the center, and the wings would extend north and south.

The plans provide for a large recreation room and storage space in the basement. The other floors were planned alike, to have a stairway, elevator, ward kitchen, and nurses' room with toilet and closet, on one side of a center hall; and on the other side 4 toilet and bathrooms, each floor to have 2 tubs, 12 wash basins, 6 water closets, and 2 slop sinks. In order to encourage proper bathing each basin should be in a separate alcove, where complete privacy could be had.

A wide hall would extend the whole length of the building, with glazed doors at each end and a door opposite the stairs opening upon the balconies. The arrangement of beds cannot be described in detail here because it is part of the plans of a tuberculosis hospital not yet built and the designers are not quite ready to make the plans public. The arrangement is such that each patient would be given the privacy of a cubicle opening directly on to a wide balcony, with a door wide enough to move the bed through, and a complete circulation of air would be obtained in each cubicle, no matter what the direction of the wind or how severe a storm might be. The cubicles could all be connected so as to permit passing through them, or, if any patient's condition should require a warm room any one of the cubicles could be closed off from the rest, making an isolation room opening into the central hall. The central hall would be kept warm, and small warmed dressing rooms for each patient would be located close by each bed. Thus, in dressing and in passing to and from the toilet and bathrooms the patients would not come into contact with a cold atmosphere as is commonly the

case. The small dressing rooms would have sufficient space for all the patient's belongings always close at hand.

A desirable feature of such a tuberculosis building is the arrangement of balconies to extend completely around the building. This would afford a place to walk without having to go down to the ground, and enable patients to reach the toilets without having to pass through the building, thus keeping them more out of doors.

For such a building a cost per cubic foot of 30 cents has again been taken as a standard. The square foot area per bed works out at 264 square feet. This looks large, but a portion of it is due to the generous extent of the balconies. The cubic foot space per bed is 2,130 cubic feet. When corrected for the lower cost of the balconies the cost per bed would be $639.

While the provisions of the building may seem almost extravagant, the planning has resulted in a cost which is unexpectedly low.

First Tuberculosis Pavilions, Riverside Hospital
Department of Health

The tuberculosis pavilions of the Department of Health on North Brother Island are remarkable for their compactness. There are four pavilions, built at two different times, and all are of reinforced concrete, 4 stories high. The center of each building is occupied by administration rooms, with two wings for wards extending east and west. There are no balconies, as the wards have windows on three sides, which are expected to give the patients all the fresh air required.

The general rooms of the first pavilions consist of a toilet room opening out of each ward, with 1 tub and 1 shower for each floor, or 1 tub or shower for every 10 patients, compared with 1 for every 20 patients in the standard; 2 basins for each ward of 10 beds, or 5 patients to a basin, compared with 3 in the standard building; 1 water closet for every 10 patients, compared with 1 for every 7 patients in the standard. Each floor also has a kitchen, with dumbwaiter, and a nurse's room. On the other side there is a large day room, directly between the 2 wards, with plate glass in the partitions to facilitate supervision.

The wards have a capacity of 10 beds each, and glass partitions have been placed between every 2 beds. While all the wards are not yet arranged this way, this maximum capacity has been assumed for the buildings.

No dressing rooms or lockers are provided for the patients and no elevator has been installed, and the patients at present go to an outside dining room for their meals.

The cost per bed of the first two pavilions was lower than that of any other tuberculosis or ward building studied. This was due to a number of causes. The cost per cubic foot was a little higher than that of the standard, chiefly because of very expensive foundations, and the location on North Brother Island was another factor. But this higher cost has been more than made up for by the compactness of the building. The square foot area and cubic foot space per bed are much less than in the standard, the chief cause of which can be seen in the ward dimensions and air space. The wards provide 71 square feet of floor per bed, while the lowest ward has 588 cubic feet per bed.

This last figure would be considered too low, except for the fact that the wards are intended for open air treatment and consequently are ex-

posed to direct ventilation from the outside. If the beds in each ward were allowed 1,200 cubic feet of space there would be only 5 beds in a ward instead of 10. This, of course, would double the cost per bed as well as the space per bed.

It will be noticed that the height of the floors is unusually low, giving practically a 9-foot ceiling. The ceiling of the upper floor is only 8 feet 4 inches high, but this story was an afterthought, and has been made higher in the later pavilions.

Second Tuberculosis Pavilions, Riverside Hospital
Department of Health

The latest tuberculosis pavilions at North Brother Island are much like the first, except that the dimensions have been increased so as to provide larger wards, a higher upper floor, and a better arrangement of the administration rooms. These changes have increased the square foot area and cubic foot space per bed, and also the cost per cubic foot, the latter about 14 per cent. The resulting cost per bed was slightly higher than that of the standard, but this can all be attributed to the location and expensive foundations. The square foot area per bed and cubic foot space per bed are less than in the standard. If 1,200 cubic feet of space were allowed per bed in the wards there would be 5 beds in a ward instead of 10, as in the first buildings.

Standard Tuberculosis Pavilion for Advanced Treatment

In working out a standard tuberculosis pavilion the lines of the standard ward building were followed in several respects. A 4-story building was planned, with a large ward on each floor, having a capacity of 32 beds, divided by screens into units of 8 beds each. 100 square feet of floor were allowed for each bed, and a 12-foot ceiling provided 1,200 cubic feet per bed. Toilets and utility sinks were provided at the far end of the ward, and wide balconies on each side, large enough to hold all the beds in the wards.

The administration end of the pavilion would have a large ward kitchen; a patients' toilet room, with 4 basins in alcoves and 4 water closets; a large bathroom, into which a patient could be wheeled; locker room, with locker for each patient's belongings; linen room; elevator; stairway; and 4 single quiet rooms. The dimensions of these rooms would follow closely those of one of the best designed tuberculosis pavilions in the country.

The 4 floors would be alike, with a ward on the roof. The whole building would have a capacity of 144 beds and the standard cost would be 30 cents per cubic foot, as in the other standards.

West Tuberculosis Infirmary, Metropolitan Hospital
Department of Public Charities

The tuberculosis pavilion of the Metropolitan Hospital that was built first is the West Infirmary. It is a stone building, with concrete floors, and there are 4 wards on each floor, with groups of administration rooms between the wards. In the center of each floor there are an examining room, 2 dressing rooms, and a storeroom. At each end are the main administration rooms, each serving 2 wards. These consist of a lavatory, with 6 basins in alcoves; 2 bathtubs; diet kitchen, with dining table; linen closet; emergency room; utility room; nurses' toilet room; patients' toilet room, with 6 water closets; stairway; and elevator.

The wards were originally designed for 14 beds, with a doorway between every 2 beds, or 6 doors on each side of a ward, giving access to the wide balcony on each side of each ward.

The cost per cubic foot of the West Infirmary was about that of the standard, but the cost per bed was higher, due to a larger square foot area and cubic foot space per bed. The administration space is considerably larger than in the standard, and the space per bed in the wards less.

The height between floors is the same as in the standard, except the height between the upper floor and the roof. This is 18 feet 6 inches, with at least 7 feet of space between the ceiling of the upper floor and the roof. The pavilions on North Brother Island have only 13½ and 13¾ inches, respectively, at this point.

North Wing, East Infirmary, Metropolitan Hospital
Department of Public Charities

This building completes the East Infirmary, making it the same size as the West Infirmary. It is a 4-story structure of stone, with concrete floors, and similar to the north end of the West Infirmary; as to dimensions, size of wards, balconies, and general arrangements. Changes have been made in the administration rooms, however, effecting considerable economy of space and providing 16 more beds in this half of the East Infirmary. The diet kitchen has been omitted on the 3 lower floors, because many of the patients go to the common dining room. The space thus saved has been used on the first floor for 4 isolation rooms, and on the second and third floors for 2 small wards of 6 beds each.

Although the cost per cubic foot of this wing was higher than that of the West Infirmary the cost per bed was lower, because of the provision for a larger number of beds. The cost per bed of this building was slightly lower than that of the standard.

Pavilions 1 and 8, Sea View Hospital
Department of Public Charities

These are the latest pavilions at Sea View Hospital and not yet completed. They are being built of steel, with hollow tile walls and floors, 4 stories high. The administration end of each floor contains a serving kitchen; nurses' room, with medicine cabinet; utility room; storeroom; isolation room; elevator; stairway; cedar lined linen room; bathroom, with tub and shower; and patients' toilet.

The remainder of each floor in both buildings comprises 3 wards extending at right angles to the front part and parallel with each other, the whole in the form of the letter T, the center ward having 16 beds and the side wards 6 beds each. On each side of the buildings is a wide balcony, to which access is had by numerous doors opening out of the 3 wards. The roof is available for use, having the necessary administration rooms.

The cost per cubic foot of the buildings was higher than that of the standard; but this is not surprising, considering the inaccessibility of the site. The cost per bed was slightly higher than that of the standard, partly because of the higher cost per cubic foot, as the square foot area per bed and cubic foot space per bed are less than in the standard, which is probably due to the fact that the cubic foot area per bed in the wards is considerably lower than in the standard. Allowing 1,200 cubic feet per bed in the 3 wards on a floor, the capacity of the buildings would be reduced about 14 per cent. The height of floors is about the same as in the standard.

FIGURES OF A NURSES' HOME IN A NEIGHBORING CITY SELECTED AS A STANDARD.

Department		Health	Health	Public Charities	Public Charities	Public Charities	Public Charities	Bellevue and Allied Hospitals	Public Charities
Hospital	Standard	Riverside	Kingston Avenue	Metropolitan	Sea View	Kings County	Children's, R.I.	Fordham	Greenpoint
Building		Nurses' Home	Nurses' Home	Nurses' Home	Nurses' Home and Help Quarters	Nurses' Home	Nurses' Home	Nurses' Home	Nurses' Home
Material of walls	.....	Brick	Brick	Stone	Terra cotta	Brick	Brick	Brick	Brick
Material of floors	.....	Terra cotta	Terra cotta	Concrete	Terra cotta	Concrete	Concrete	Wood	Concrete
Material of roof	.....	Wood, slated	Wood, slated	Steel, concrete, tin	Steel, Terra cotta, tile	Concrete	Concrete	Wood, slated	Steel, concrete, tile
Character of roof	Flat	Sloping	Sloping	Sloping	Sloping	Flat	Flat	Sloping	Sloping
Number of nurses' beds, as planned	.....	60	91	122	117	129	68	35	50
Number of help's beds, as planned	.....	0	0	35	16	12	12	0	0
Total number of beds, as planned	.....	60	91	157	133	141	80	35	50
Total cost, excluding architect	.....	$98,611	$108,100	$338,763.10	$242,000	$246,255.93	$137,803	In general contract	Contract not awarded
Cost per bed	$1,284	$1,643	$1,190	$2,157	$1,820	$1,747	$1,723	.....	.....
Cost per square foot	$3.06	$3.71	$3.72	$4.12	$4.82	$3.69	$3.30	.....	.....
Cost per cubic foot	30 cents	35.9 cents	34.4 cents	39.7 cents	44.8 cents	29.1 cents	30.6 cents	.....	.....
Square feet per bed	420	443	319	523	378	473	522	500	* 341
Cubic feet per bed	4,280	4,575	3,450	5,430	4,050	6,000	5,635	4,860	* 4,286
General rooms, square feet per nurse	31	26	30	38	27	54	33	39	* 39
Teaching rooms, square feet per nurse	10	.....	.....	16	7	19	24	8	* 30
Dining rooms, square feet per nurse	11	9	8	22	13	13	18	10	22
Kitchen, pantry, etc., square feet per nurse	18	13	8	13	19	8	19	18	.....
Infirmary rooms, square feet per nurse	11	.....	.....	13	11	17	24	12	.....
Bathtubs and showers, beds to each	6	9½	8	5	8	8	.....	6	
Water closets, beds to each	6	6	10	7	5	7	.....	6	
Wash basins, beds to each	1	5	7	3½	1	1	.....	3	
Height of floor, sub-basement to basement	.....	.....	.....	.....	9'8"	.....	.....	.....	.....
Height of floor, basement to first	.....	7'8"	9'4"	9'	11'3"	10'6"	9' to 15'	11'	9'3"
Height of floor, first to second	10'6"	12'	12'	14'	12'2"	15'2"	13'	11'4"	12'
Height of floor, second to third	10'	10'2"	10'4"	11'	10'4½"	11'1"	11'	10'4"	12'
Height of floor, third to fourth	9'6"	10'2"	10'4"	11'	.....	11'1"	11'	10'4"	.....
Height of floor, fourth to fifth	.....	.....	.....	11'	.....	14'	.....	.....	.....
Height of floor, upper floor to ceiling	8'6"	8'8"	9'	9'	8'6"	12'7"	9'6"	9'	10'6"
Height of floor, upper floor to roof	11'	.....	.....	.....	.....	12'6"	13'6"	.....	.....
Height of space, upper ceiling to roof	2'6"	.....	.....	.....	.....	.....	4'	.....	.....
Nurses' bedrooms for one bed	All	60	47	122	101	129	58	20	50
Nurses' bedrooms for two beds	.....	.....	22	.....	6	.....	4	6	.....
Nurses' bedrooms for three beds	.....	.....	.....	.....	.....	.....	.....	1	.....
Nurses' bedrooms for four beds	.....	.....	.....	.....	1	.....	.....	.....	.....
Help's bedrooms for one bed	.....	.....	.....	3	16	12	8	.....	.....
Help's bedrooms for two beds	.....	.....	.....	5	.....	.....	2	.....	.....
Help's bedrooms for three beds	.....	.....	.....	6	.....	.....	.....	.....	.....
Help's bedrooms for four beds	.....	.....	.....	1			.....	.....	.....
Nurses' rooms, dimensions of smallest	8'6"x13'x8'6"	9'6"x12'6"x9'	9'x13'x9'	14'6"x8'10"x 9'7"	7'9"x16'7"x9'	9'6"x11'6"x10' 4"	.....	12'x12'x10'4"	8'x14'6"x10'6"
Nurses' rooms, square feet in smallest	110	119	117	128	129	109	.....	144	116
Nurses' rooms, cubic feet in smallest	935	1,069	1,053	1,230	1,161	1,125	.....	1,490	1,218
Help's rooms, dimensions of smallest	.....	.....	.....	.....	7'x8'6"x8'6"	.....	6'6"x12'x9'6"	.....	.....
Help's rooms, square feet in smallest	.....	.....	.....	(per bed) 74	61	.....	78	.....	.....
Help's rooms, cubic feet in smallest	.....	.....	.....	(per bed) 666	485	.....	741	.....	.....

* For the purpose of properly comparing this Home with the Standard, the space provided in the main hospital building for the nurses, except dining room and infirmary, was included in these figures.

DORMITORIES.

THIS TABLE SHOWS THE COST OF VARIOUS BUILDINGS OF THIS CHARACTER AND ALSO THE AMOUNT OF SPACE PROVIDED FOR THE VARIOUS FUNCTIONS OF EACH, IN COMPARISON WITH LIKE FIGURES OF A SPECIALLY DESIGNED STANDARD.

Department		Health	Health	Public Charities	Public Charities	Public Charities	Bellevue and Allied Hospitals
Hospital	Standard	Willard Parker	Riverside	Metropolitan	City	Greenpoint	Bellevue
Dormitory		Maids	Maids	Female Help	Female Help	Male Help	Male Help
Material of walls	.....	Brick	Concrete	Stone	Stone	Brick	Brick
Material of floors	.....	Concrete	Concrete	Concrete	Concrete	Concrete	Terra cotta
Material of roof	.....	Concrete	Concrete	Concrete	Concrete	Steel, con., tile	Terra cotta
Character of roof	.....	Flat	Flat	Flat	Flat	Sloping	Flat
Number of beds, as planned	.....	163	103	99	42	52	246
Total cost, excluding architect	.....	$103,227	$95,340	$118,939.08	$47,700	Not cont'd for	$291,964
Cost per bed	$600	$633	$926	$1,202	$1,135	.....	$1,186
Cost per square foot of building	$3.00	$3.33	$3.83	$3.53	$3.25	.....	$6.46
Cost per cubic foot of building	30 cents	27.5 cents	30 cents	32.6 cents	31.2 cents	.....	41 cents
Square feet of building per bed	200	190	242	340	349	327	184
Cubic feet of building per bed	2,000	2,300	3,080	3,680	3,630	4,125	2,890
Sitting rooms, square feet per bed	10	10	12	8	20	9	18
Bathtubs and showers, beds to each	8	13	11	6½	7	9	14
Water closets, beds to each	6	8	6	4	7	9	10
Wash basins, beds to each	4	5	4	4	3½	1	7
Height of floor, sub-basement to basement	.....	.....	.....	.....	.....	.....	15'6"
Height of floor, basement to first	9'3"	9'4"	9'4"	9'	9'	9'3"	15'
Height of floor, first to second	9'6"	13'4"	13'2"	12'	11'6"	12'	18'6"
Height of floor, second to third	9'6"	12'	12'	11'	11'	12'	15'8"
Height of floor, third to fourth	9'6"	12'	12'	10'6"	.....	.....	15'
Height of floor, fourth to fifth	9'6"	12'	.....	.....	.....	.....	15'
Height of floor, fifth to sixth	.....	.....	.....	.....	.....	.....	15'
Height of floor, sixth to seventh	.....	.....	.....	.....	.....	.....	19'8"
Height of floor, upper floor to ceiling	8'6"	11'	11'6"	10'	9'5"	10'6"	8' and 13'
Height of floor, upper floor to roof	11'	12'10"	14'5"	13'4"	11'3"	.....	19'
Height of space, upper ceiling to roof	3'6"	1'10"	2'9"	3'4"	1'8"	.....	6'
Total number of bedrooms	.....	14	13	91	42	52	69
Bedrooms for one bed	All	1	7	83	42	52	0
Bedrooms for two beds	.....	5	.....	8	.....	.....	16
Bedrooms for three beds	.....	.....	.....	.....	.....	.....	22
Bedrooms for four beds	.....	.....	.....	.....	.....	.....	7
Bedrooms for five beds	.....	.....	.....	.....	.....	.....	24
Bedrooms for more than five beds	.....	8	6	.....	.....	.....	.....
Maximum number of beds in one room	.....	20	16	2	1	1	5
Dimensions of smallest bedroom	8'x12'x8'6"	.....	10'x14'x11'4"	8'11"x11'3"x9'2"	8'7"x11'5"x10'	8'x14'6"x10'6"	.....
Square feet in smallest bedroom	96	.....	140	100	98	116	.....
Cubic feet in smallest bedroom	816	.....	1,587	917	980	1,218	.....

WARD BUILDINGS.

THIS TABLE SHOWS THE COST OF THE VARIOUS BUILDINGS OF THIS CHARACTER AND ALSO THE AMOUNT OF SPACE PROVIDED FOR THE VARIOUS FUNCTIONS OF EACH, IN COMPARISON WITH LIKE FIGURES OF A SPECIALLY DESIGNED STANDARD.

Department		Health	Health	Bellevue and Allied Hospitals	Bellevue and Allied Hospitals	Bellevue and Allied Hospitals	Public Charities	Public Charities	Public Charities
Hospital	Standard	Willard Parker	Kingston Avenue	Bellevue	Bellevue	Harlem	Kings County	Kings County	Greenpoint
Building		Measles Pavilion	Isolation Pavilion	Pavilions A and B	Pavilions L and M	New Wing	New Ward Wing	Children's Hospital	Main Building
Material of walls	.....	Concrete	Brick	Brick	Brick	Brick	Brick	Brick	Brick
Material of floors	.....	Concrete	Concrete	Terra cotta	Terra cotta	.....	.....	.....	.....
Material of roof	.....	Concrete	Concrete	Terra cotta	Terra cotta	.....	.....	.....	.....
Character of roof	.....	Flat	Flat	Flat	Flat	Flat	Flat	Flat	Sloping
Number of beds, as planned	.....	312	92	396	427	134	200	150	167
Total cost, excluding architect	.....	$227,763	$62,625	$748,919	$748,840	$258,461	$170,946	$137,360	$384,525
Cost per bed	$902	$730	$680	$1,890	$1,755	$1,928	$855	$915	$2,300
Cost per square foot of building	$3.83	$4.27	$3.66	$6.35	$5.65	$5.12	$3.80	$4.03	$3.48
Cost per cubic foot of building	30 cents	36.6 cents	33.4 cents	41.6 cents	36.7 cents	34 cents	28.4 cents	28.7 cents	26.5 cents
Square feet of building per bed	236	171	186	298	311	377	225	227	662
Cubic feet of building per bed	3,008	1,995	2,035	4,550	4,780	5,670	3,008	3,190	8,680
Dimensions of typical ward	40'x80'	60'9"x27'2"	30'x44'	30'x89'	29'9"x88'	.....	.....	.....	26'x63'6"
Number of beds in typical ward	32	24	36	24	26	.....	.....	.....	.....
Square feet per bed in typical ward	100	68	37	117	106	.....	.....	.....	.....
Cubic feet per bed in typical ward	1,200	750	438	1,523	1,383	.....	.....	.....	.....
Total beds if 1,200 cubic feet per bed	.....	194	46	480	483	.....	.....	.....	.....
Beds in ward if 1,200 cubic feet per bed	.....	14	13	30	30	.....	.....	.....	14
Square feet per bed if 1,200 cubic feet per bed	100	117	110	94	92	.....	.....	.....	104
Cost per bed if 1,200 cubic feet per bed	$902	$1,173	$1,360	$1,560	$1,548	.....	.....	.....	$2,850
Square feet of building if 1,200 cubic feet per bed	236	275	372	246	274	.....	.....	.....	818
Cubic feet of building if 1,200 cubic feet per bed	3,008	3,210	4,075	3,760	4,225	.....	.....	.....	10,750
Height of floor, sub-basement to basement	.....	.....	.....	12'6"	12'6"	.....	.....	.....	.....
Height of floor, basement to first	9'	9'	9'3"	15'	15'	13'	10'2"	13'8"	9'3"
Height of floor, first to second	13'	11'6"	12'2"	18'6"	19'6"	15'	14'3"	14'3"	12'6"
Height of floor, second to third	13'	12'	.....	15'8"	15'8"	15'	14'3"	14'3"	15'7½"
Height of floor, third to fourth	13'	12'	.....	15'	15'	15'	14'3"	14'3"	15'7½"
Height of floor, fourth to fifth	13'	12'	.....	15'	15'	17'	.....	.....	15'7½"
Height of floor, fifth to sixth	.....	12'	.....	15'	15'	.....	.....	.....	.....
Height of floor, sixth to seventh	.....	11'6"	.....	.....	.....	.....	.....	.....	.....
Height of floor, upper floor to ceiling	12'	10'6"	12'	13'	13'	.....	.....	.....	.....
Height of floor, upper floor to roof	14'6"	11'6"	14'8"	19'	19'6"	16'	14'9"	15'4"	.....
Height of space, ceiling to roof	2'6"	1'	2'8"	6'6"	6'6"	.....	.....	.....	.....

TUBERCULOSIS PAVILIONS.

THIS TABLE SHOWS THE COST OF VARIOUS BUILDINGS OF THIS CHARACTER AND ALSO THE AMOUNT OF SPACE PROVIDED FOR THE VARIOUS FUNCTIONS OF EACH, IN COMPARISON WITH LIKE FIGURES OF A SPECIALLY DESIGNED STANDARD.

	For Incipient Cases			For Advanced Cases			
Department		Health	Health		Public Charities	Public Charities	Public Charities
Hospital	Standard	Riverside	Riverside	Standard	Metropolitan	Metropolitan	Sea View
Building		Concrete Pavilion, 1st Type	Concrete Pavilion, 2d Type		West Infirmary	East Infirmary North Wing	Pavilions Nos. 1 and 8
Material of walls	Concrete	Concrete	Concrete	Concrete	Stone	Stone	Terra cotta
Material of floors	Concrete	Concrete	Concrete	Concrete	Concrete	Concrete	Terra cotta
Material of roof	Concrete	Concrete	Concrete	Concrete	Concrete	Concrete	Terra cotta
Character of roof	Flat	Flat	Flat	Flat	Flat	Flat	Flat
Number of beds, as planned	160	80	80	144	224	128	116
Total cost, excluding architect	.....	$46,250	$52,544	.....	$269,612	$134,900	$136,750
Cost per bed	$539	$578	$657	$1,086	$1,204	$1,054	$1,180
Cost per square foot of building	$2.42	$3.12	$3.39	$3.60	$3.50	$3.77	$4.70
Cost per cubic foot of building	30 cents	32.2 cents	34.1 cents	30 cents	30.8 cents	31.7 cents	35.5 cents
Square feet of building per bed	264	185	194	294	335	279	251
Cubic feet of building per bed	2,130	1,798	1,927	3,620	3,910	3,330	3,320
Dimensions of typical ward	.....	44'2"x16'	47'6"x15'10"	40'x80'	51'x26'6"	50'6"x26'6"	44'x20'
Number of beds in typical ward	.....	10	10	32	14	14	16
Square feet per bed in typical ward	85	71	75	100	97	96	96
Cubic feet per bed in typical ward	610	588	677	1,200	1,157	1,058	1,055
Total beds if 1,200 cubic feet per bed	.....	40	40	144	192	112	100
Beds in ward if 1,200 cubic feet per bed	.....	5	5	.....	12	12	14
Square feet per bed if 1,200 cubic feet per bed	.....	141	150	100	113	112	110
Cost per bed if 1,200 cubic feet per bed	.....	$1,156	$1,314	$1,086	$1,404	$1,204	$1,368
Square feet of building if 1,200 cubic feet per bed	.....	370	388	294	391	319	391
Cubic feet of building if 1,200 cubic feet per bed	.....	3,596	3,853	3,620	4,565	3,800	3,855
Height of floor, sub-basement to basement	.....	.....	.....	.....	.....	.....	.....
Height of floor, basement to first	9'	7'11¼"	8'	9'9"	9'	9'	8'9"
Height of floor, first to second	11'	10'6"	10'6"	13'	13'	13'	13'4"
Height of floor, second to third	11'	10'	10'3"	13'	13'	13'	13'4"
Height of floor, third to fourth	11'	10'	10'	13'	13'	13'	13'4"
Height of floor, fourth to fifth	.....	.....	.....	.....	.....	.....	.....
Height of floor, fifth to sixth	.....	.....	.....	.....	.....	.....	.....
Height of floor, sixth to seventh	.....	.....	.....	.....	.....	.....	.....
Height of floor, upper floor to ceiling	10'	8'4"	9'	12'	11'6"	11'6"	11'
Height of floor, upper floor to roof	11'	9'5½"	10'1¾"	14'6"	18'6"	18'6"	16'10"
Height of space, upper ceiling to roof	1'	1'1½"	1'1¾"	2'6"	7'	7'	5'10"

3. INTERNAL CONTROL FORMS SUGGESTED FOR BELLEVUE HOSPITAL

The Need

The head of any large department, establishment, or institution must judge of the efficient operation of the various functions under his control by synoptical reports laid before him at stated periods. These reports must summarize the daily operation of the various functions in such a way that the information contained therein will indicate to the directing head whether or not any particular activity is being properly conducted. It is possible to report on almost any activity in such a way that one familiar with the results that should be obtained can readily judge whether or not the expected results are being secured.

It is impossible for the superintendent of an institution the size of Bellevue Hospital to personally supervise daily all of the activities of the institution. Their direction must be left to subordinate heads, and of these heads there are so many that if the superintendent should endeavor to confer with each at frequent intervals his time would be almost entirely occupied with conferences. For the proper conduct of the institution it is necessary to have reports come to his desk, setting forth what each activity has accomplished within a stated period, and setting it forth in such a manner that the report will clearly show whether it is being properly conducted.

Such reports would rarely indicate the particular thing that might be out of adjustment, but they would, if the proper information were incorporated, show that something was wrong, and also in what department of the institution it existed. Having ascertained from a report of a particular activity that the results expected were not being secured, it would be necessary for the superintendent to call before him the head of that activity for a detailed explanation of the summarized information in the report.

Even with the best of control reports in operation it would be necessary for the directing head to have periodic conferences with the heads of the various activities and departments, for the purpose of keeping more closely in touch with the work, and also for the purpose of giving directions. Such conferences are also useful in defining the work of each department and activity, and in creating a closer understanding and coöperation between different heads.

Generally speaking, public institutions are very deficient in control measures and forms. The same statement could have been made of business generally until within the last few years. The public accountant and efficiency engineer have done much toward systematizing large business undertakings and developing forms of reports and memoranda which enable the directing head to constantly know the condition of affairs in every branch and department of a business. Comparatively little attention has been given to such matters in public institutions, and as a result they are not as efficiently conducted as private enterprises handling a corresponding amount of money.

Bellevue Hospital was selected in which to make an examination of the various activities for the purpose of determining whether or not the con-

trol forms used at present are adequate and the organization efficient. But the selection was not made because it was assumed that at the present time Bellevue is less efficient than our other public institutions. In fact, it seems to be operated with as great efficiency as any of the City's institutions, and much more ably than some of them. Bellevue was chosen because the Committee is suggesting a reorganization of the medical service in this Hospital, and it was deemed advisable at the same time to reorganize the administrative department of the institution. It is hoped, however, that the forms suggested for Bellevue will serve as a basis for all of the hospitals in the City, with such modifications as may be necessary to adjust them to local conditions. In this connection it should be stated that Bellevue lacks subordinate administrative officers. The Superintendent, without a departmental assistant, is supposed to direct the activities not only of Bellevue, but of three allied hospitals located in different parts of the City, an impossible task for one man to perform. Associated with him is an Assistant Superintendent, whose entire time is occupied with the affairs of Bellevue Hospital alone. Many of the shortcomings in the administrative department of Bellevue are due to the undermanned condition of the department.

The administrative organization of Bellevue and Allied Hospitals may be described as follows:

A Board of (seven) Trustees appointed by the Mayor has charge of all the affairs of the allied hospitals. They entrust the direction to a Superintendent, who supervises not only Bellevue Hospital, but the three allied hospitals. The Superintendent has one assistant, who is occupied with the detailed affairs in Bellevue Hospital alone; in each of the allied hospitals there is a Superintendent; and associated with the Superintendent of each hospital there is a Storekeeper, who acts in the capacity of an Assistant Superintendent. At Bellevue Hospital there is a Contract Clerk, whose function is primarily that of auditor and bookkeeper for the entire Department. Associated with him as an assistant is a Purchasing Agent, who purchases supplies for the Department. The Purchasing Agent, under the supervision of the Contract Clerk, makes all open order purchases or contracts for food and supplies. The Storekeeper has charge of the receipt and distribution of food and supplies. The laundry is in charge of a trained nurse, under whom there is an experienced laundryman. The Dietitian has charge of the requisitions for the Department and the preparation and service of food in Bellevue Hospital. A Supervising Engineer has charge of engineering matters in the whole Department, with an engineer in charge of each plant. One man has entire charge of the ambulance service and also the work about the grounds. Repairs to the physical plant are in charge of the Supervising Engineer.

The nursing in Bellevue is conducted and supervised by the Training School for Nurses, an independent organization with which the Trustees of Bellevue Hospital contract for the services rendered. It is not responsible to the Superintendent of the Hospital, and makes no reports to him, and the only method of coördinating the work of the Superintendent and that of the Training School for Nurses is periodic conferences.

The social service work of the Hospital is conducted by a voluntary committee, in whose service there are officers who are paid by the Hospital. These officers, or the Committee, make no periodic reports to the Superintendent about the work performed, and are practically as independent of his supervision as is the Training School for Nurses. The

Social Service Department is supposed to be a department of the Training School for Nurses and under its supervision.

Inasmuch as a new system of medical service for Bellevue has been recommended by the Committee, and will probably be installed, it seemed inadvisable to suggest records dealing with the medical service, since a changed form of service may require forms and reports which cannot readily be foreseen at the present time.

The Committee has confined its attention to forms intended to regulate the operation of the physical plant and the use of materials and supplies. Also, certain forms are submitted designed to give the Superintendent of the Hospital some supervision over the work of the Training School for Nurses and the Social Service Department.

The forms submitted are not intended to be a complete set of forms needed for the operation of the Hospital. They are only meant to provide more adequate forms than those in use and to supply forms for reports which are not now made. No attempt has been made to revise forms that are satisfactory, nor are they included among the forms presented.

In drafting the forms on which statistical reports are to be made the statistical data of the annual report has been kept in mind, and the periodic reports from the departments made to conform, so far as possible, to the needs of the annual report.

Additional accounting is needed in connection with the consumption of various supplies; such as cleaning supplies, laundry materials, etc. The Comptroller's Department has provided a system of accounting for most of the supplies used in the hospitals, and in such accounting there will be set forth the amount of the items mentioned above. It seems to the Committee that it would be highly advisable if the Hospital would select from such accounting particular articles or classes of articles about which to require separate reports, inasmuch as it is very difficult for a busy supervising officer to examine in detail a report covering many pages and several hundred articles—the important articles would be overlooked in the mass of details.

Suggested Forms

Accounting for Food and Materials

Report on Regular and Special Diets

The record of the regular and special diets is kept at present by the Dietitian, but no report is sent to the Superintendent of the Hospital. The form on page 688 is designed as the basis for such report.

[Forms dealing with the distribution of, and accounting for, food are included in Part I of this Section of the Report.]

Condemned Articles

At the present time there is no report made by condemning officers of the number of articles condemned. The system is to bring back a worn-out article and exchange it for a new one of like character without a record being made of the fact that an article has been condemned, and no record exists in the Hospital of the total number of the various classes of articles

FORM No. 1

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF REGULAR AND SPECIAL DIETS PREPARED IN DIETARY DEPARTMENT

Month ended.....19....

[8½ x 11½ inches]

Day	Uniform Diets			Special Sick Diets				Regular	Total
	Low Chlorine	Low Nitrogen	Low Carbohydrates	1st Division	2d Division	3d Division	4th Division		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
Total.									

Report to be made monthly to the General Medical Superintendent.

thus condemned. The following forms were designed to provide a record of all condemnations, so that the Superintendent may readily note the rapidity with which the various articles are being worn out or destroyed, and by comparison of the list of condemned articles with new issues an estimate can be made by the Superintendent of the number of missing articles.

Form No. 2 is to be made out by heads of various divisions and presented with the articles to be condemned to the condemnation officer in charge of the class of articles to be condemned, and after the list of articles has been condemned and the Superintendent has affixed his signature approving it the list may be used as a requisition for a like number of similar articles. A duplicate copy of such list is to be kept by the condemning officer as a basis of monthly report to the Superintendent.

Form No. 3 provides for a monthly report by the condemnation officer.

FORM No. 2

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

CONDEMNED ARTICLES

The following articles have been inspected by me and condemned. This list will be accepted as a REQUISITION for the issue of articles to take the place of the articles condemned.

[5½ x 8½ inches]

1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
		Last line used, No.		

Signed.....

Approved:.....Superintendent

FORM No. 3

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

CONDEMNED ARTICLES

Month ended.....19....

	Ward.....			Ward.....			Ward.....			Additional columns provide for all wards, dietary, laundry, and other general departments.	Total		
	Condemned Returned	Issued	Unaccounted For	Condemned Returned	Issued	Unaccounted For	Condemned Returned	Issued	Unaccounted For				
List such articles as are likely to be used carelessly or issued too freely.													

This form, 17 x 17 inches, provides space for 16 columns for wards and departments, and 2¼ inches for margin for binding space, and is the second page of the leaf; second and third pages provide 32 columns, and are 15½ x 17 inches; the fourth page provides 18 columns, and is the same size as the first page.

Accounting for Expensive Drugs

Although the forms of accounts provided by the Comptroller provide for the accounting of the distribution of drugs, such account is not kept according to the Divisions of the Hospitals and according to the Medical and Surgical Services. It seems advisable to suggest a separate report upon the more expensive drugs, and Form No. 4 would serve this purpose.

Requisitioning Food Supplies

The form of requisition for food supplies at present used in Bellevue Hospital is inadequate to give a complete check upon the issue and the receipt of such supplies. It records the amount ordered by the Dietitian and the amount sent from the storehouse or butcher shop, but does not provide for the entering of the amount actually received in the various departments. It is highly important that the amount actually received be entered by the person responsible for receiving the goods, and that the requisition be signed by such agent as having received them, with the amount indicated opposite each article thus received. If there is any dis-

FORM No. 4

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

MONTHLY REPORT OF CONSUMPTION OF EXPENSIVE DRUGS, SURGICAL SUPPLIES, AND ALCOHOLIC LIQUORS DISPENSED TO WARDS, ETC.

Month ended.....19....

[7 x 17 inches]

Articles	Unit	Medical							Surgical							Outlying and Other Services														Total Consumed	Stock Report						
		1st	2d	2d Gyn.	3d Gyn.	3d	4th	4th Gyn.	Total	1st	1st G. U.	2d	2d G. U.	3d	3d G. U.	4th	Total	30-34-36	22-26-27	28-31	38-39	44	A. B. C.	Dressing Office	Amphitheatre	Pathological							Total		Stock on Hand Last Month	Received During Month	Total to be Accounted For	Dispensed	Stock Remaining	Actual Stock Remaining	Balance Unaccounted For
List alphabetically the more important or more expensive drugs and surgical supplies.	Indicate in this column unit of quantity of each.																																				
Include at end of list: Alcohol, Brandy, Port, Sherry, Whiskey																																					

This report to be made out by the druggist monthly. The stock report should be carried out for alcoholic liquors and for any other listed drugs as required by the General Medical Superintendent.

crepancy between the amount sent from the storehouse and the amount received the following form of requisition (No. 5) will make clear such discrepancy. The lines are numbered, and a space is provided for the approving officer to indicate the last line on which an item is entered, thus safeguarding against additional entries after the approving officer has affixed his signature.

FORM No. 5

	Paid	Unpaid
No. of Officers		
No. of Staff and extra		
No. of Employees		
Total		

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REQUISITION FOR FOOD SUPPLIES

Month ended.....19....

The following supplies are requested for.....

Signed.....

[8½ x 11 inches]

Line	Quantity Needed	Quantity Issued	Quantity Received	✓	ARTICLES	Remarks
1						
2						
3						
4						
5						
6						
7					To be made out in triplicate.	
8						
9						
10						
11						
12						
13						
14						
15						
&c.						

The above articles were received in this department.....19... and were weighed, counted, or measured.

Signed.....

White form for personnel.

Colored form for patients or inmates.

Approved for issue

By.....

Last line used No. .....

(✓) Check column to be used by the Dietitian.

The following is to be added to the above form when used in making requisitions for supplies for patients or inmates:

Number of patients receiving House Diet	
Number of patients receiving Half Diet	
Number of patients receiving Special Diet	
Number of patients receiving Extra Diet	
Number of patients receiving Tbc. Diet	
Number of patients receiving Milk Diet	
Number of patients receiving Children's Diet	
Total	

Reports by Departmental Heads of Work Accomplished

Report of Supervising Engineer

At the present time no periodic report is made by the Supervising Engineer to the Superintendent of the institution. It seems highly advisable that reports should be made showing the amount of coal consumed, water evaporated, refrigeration furnished, and ice produced and issued. Forms Nos. 6 and 7 were designed to be filled out by the Supervising Engineer and transmitted to the Superintendent.

FORM No. 6

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

COAL REPORT FOR 24 HOURS ENDED 12 O'CLOCK MIDNIGHT.....19....

COAL CONSUMED AND WATER EVAPORATED

[8½x 5½ inches]

	1st WATCH		2d WATCH		3d WATCH		TOTAL	
	Pounds Coal	Water Evaporated	Pounds Coal	Water Evaporated	Pounds Coal	Water Evaporated	Pounds Coal	Water Evaporated
Boiler No. 1								
Boiler No. 2								
Boiler No. 3								
Etc.								

This report to be made out daily and to be the basis of a monthly report to the General Medical Superintendent.

BELLEVUE AND ALLIED HOSPITALS

[Part of Form No. 6]

Bellevue Hospital

Report of Engineering Department for Month Ended.....19....

	This Month	Last Month	This Month Last Year	Remarks
Pounds coal used Pounds water evaporated Average temperature for month (Extend to include tubes and boilers cleaned)				

Report of Employment Agent

The Employment Agent at the present time renders a monthly report to the Superintendent. Such report, however, does not indicate the actual number in service. Form No. 8 provides a column for this information. Otherwise the form is similar to that now in use.

Report of the Dental Clinic

The Dental Clinic at the present time sends a daily report to the Superintendent of the Hospital but does not summarize this information and present it in the form of a monthly report. Form No. 9 is designed for such a monthly report.

Report of Bureau of Investigation

The Bureau of Investigation at the present time renders no report of its operations. It is highly important that the Superintendent should know the work that is being undertaken and what has been accomplished. Form No. 10 was designed as a monthly report of the Chief Investigator and a form somewhat similar might be used as an annual report.

Report of Social Service Bureau

The Social Service Bureau at present furnishes no formal report to the Superintendent of the Hospital. The work done by this Bureau is set forth in an annual report published by the Bureau, but no periodic report is submitted to the Superintendent which will inform him of the daily operations of that department. Form No. 11 is designed to accomplish this purpose, and includes only such information as is at the present time compiled for the annual report.

FORM No. 7

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

DAILY REPORT OF COLD STORE

To be sent daily to Supervising Engineer.

Date.....19....

[8½ x 11 inches]

Temperature	Rooms								
	A	B	C	D	E		Tank	Outside	Remarks
6 A. M. 12 M. 6 P. M.									

ICE ISSUED

Cold Store Offices Nurses' Home Milk Hall School for Attendants		Pavilion A & B &c.		Total Issued On Hand Total		

REFRIGERATING PLANT

Time	Pressure								Temperature						Ammonia Pump Strokes per Minute
	Boiler Steam	Generator Steam	Generator Ammonia	Absorber	Brine Cooler	Brine Discharge	Brine Return	Water Discharge	Outside	Brine Inlet	Brine Discharge	Condensed Water Inlet	Condensed Water Outlet	Absorber Water Outlet	
8 12 4 8 12 4															

Signature.....

FORM No. 8

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF EMPLOYMENT AGENT, MONTH ENDED.....19....
[8½ x 11 inches]

	This Month				This Month Last Year			
	Employees Allowed	Average Number Working	Total Changes	Per Cent. Changes	Employees Allowed	Average Number Working	Total Changes	Per Cent. Changes
Total								
Men								
Women								
CLASSIFIED								
Desirable								
Undesirable								
Cause of leaving: Absent								
Resigned								
Dismissed								
Departments:								
Housekeeping								
Laundry								
Main Building								
Pavilion A & B								
Dietary								
Yard								
Engineer								
Attendants								
Stables								
Storehouse								
School for Attendants								
Miscellaneous								

LENGTH OF SERVICE	In Service More Than 1 Year	9 to 12 Months	6 to 9 Months	3 to 6 Months	Less Than 3 Months			
Departments:								
Housekeeping								
Laundry								
Main Building								
Pavilion A & B								
Dietary								
Yard								
Engineer								
Attendants								
Stables								
Storehouse								
School for Attendants								
Miscellaneous								

FORM No. 9

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF WORK DONE IN DENTAL CLINIC

Month ended.....19....

[5½ x 8½ inches]

Dentists in attendance	.....
Visits of dentists during month	.....
Total hours service by visiting dentists	.....
Number of Patients—Adults	.....
Children	.....
Visits by parents	.....

Teeth cleaned	.....
Teeth extracted	.....
Teeth filled, Amalgam	.....
Teeth filled, Cement	.....
Teeth filled, Gutta Percha	.....
Teeth filled, Copper-amalgam	.....
Teeth filled, Copper-cement	.....
Treatments	.....
Fractures	.....
Surgical operations	.....
Total operations	.....

Report to be compiled monthly by the nurse, from her daily record.

Signed.....
Nurse

Report of the Pathological Department

The Pathological Department at the present time renders two reports to the Medical Board but none to the Superintendent of the Hospital. It seems advisable that such a report should be rendered, and the information called for in the two reports has been combined into one form, No. 12, to be filled out and submitted monthly to the Superintendent of the Hospital.

At the present time there is no record of the attendance of physicians at autopsies. The Hospital requires physicians to record the time of arrival at, and departure from, the Hospital. It would seem equally advisable to have a record of the attendance of physicians at autopsies. Forms Nos. 13 and 14 provide for this information.

Report of the Röntgen-Ray Department

At the present time the Röntgen-Ray Department makes no periodic report to the Superintendent of the Hospital. Form No. 15 is designed to be used for this purpose.

FORM No. 10

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

MONTHLY REPORT OF BUREAU OF INVESTIGATION

Month ended.....19....

[8½ x 11 inches]

a. Number of cases pending first day of month	.....
b. Number of new cases taken up	.....
c. Total number of cases in charge during month	.....
d. Number of interviews in Wards	.....
e. Number of interviews in O. P. D.	.....
f. Number of interviews in Field	.....
g. Number of cases pending last day of month	.....

CLASSIFICATION OF CASES

Number of classified cases pending at 1st of month	.....
Number of cases classified during month	.....

ALIENS AND NON-RESIDENTS

	Total	Ambulance	Non-Ambulance	Referred to U. S. Government	Referred U. S. Cases Removed	Referred to S. B. C.	Referred S. B. C. Cases Removed	Referred to S. B. A.	Referred S. B. A. Cases Removed	Hospital Cost (Use latest per capita daily unit.)
Aliens										
Non-residents										
Total										

Number of aliens having history of morbidity prior to landing in U. S.	.....	.....
Amount collected from U. S. Government	.....	.....
Amount collected from New York State	.....	.....
Amount collected from private sources for aliens	.....	.....
Amount collected from other paying patients	.....	.....

Chief Investigator.....

The above report to be made out monthly by the head of the Bureau and sent to the General Medical Superintendent.

The same data to be assembled by the head of the Bureau into an annual report.

FORM No. 11

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

MONTHLY REPORT OF THE BUREAU OF SOCIAL SERVICE

Month ended.....19....

[8½ x 11 inches]

Cases actively in charge first of month.....	.....
New cases taken up.....	.....
Old cases continued or reopened	.....
Patients requiring slight service, telephone messages, etc.....	.....
Patients requiring intensive social service.....	.....
Cases remaining actively in charge at end of month.....	.....

CLASSIFICATION OF CASES

	General Welfare	Child Welfare	Psychopathic Alcoholic	Total	Free Synagogue	Total	Tuberculous	General Dispensary	Total
Cases treated by the Bureau									
Visits to home by social service worker									
Miscellaneous calls by social service worker									
Hospital cases referred to other agencies									
Dispensary patients referred to other agencies									
Office interviews by social service workers									
Total									

Number of Committee meetings held.....	.....
Aggregate attendance at all Committee meetings	.....

Statistical Reports

Census Report for Wards

At the present time the report from the wards gives merely the number of admissions and discharges. It seems highly advisable to have a report from the wards daily that will indicate the names of the patients received by, and also those discharged from, such wards. This information is necessary to check the records in the admitting office showing the

FORM No. 12

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF THE PATHOLOGICAL DEPARTMENT

[8½ x 11 inches]

Month ended.....19....

	Deaths	Autopsies			Coroner's Cases	Examination of Specimens								Metabolic Analyses					
		Consent	Overdues	Total		Wassermann Reactions	Surgical Specimens	Blood Cultures						Diabetes	Nephritis				
First Medical																			
First Surgical																			
Children																			
Second Medical																			
Second Surgical																			
Second Gynecological																			
Third Medical																			
Third Surgical																			
Third Gynecological																			
Fourth Medical																			
Fourth Surgical																			
Fourth Gynecological																			
Psychopathic																			
Alcoholic																			
Prison																			
Tuberculosis																			
Obstetrical																			
School of Midwifery																			
Erysipelas																			
Reception Office																			

FORM No. 13

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

RECORD OF ATTENDANCE OF ATTENDING STAFF AT AUTOPSIES DURING MONTH

Month ended.....19....

[8½ x 11 inches]

Names	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total

FORM No. 14

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

RECORD OF ATTENDANCE OF PHYSICIANS AND SURGEONS AT AUTOPSIES DURING MONTH

Month ended.....19....

[8½ x 11 inches]

Name	Division	Number of Autopsies	Times Present at Autopsies of His Division	Times Present at Other Autopsies	Total Autopsies Attended

assignment and discharge of patients. Form No. 16 provides for the recording of such information.

Form No. 17 provides for the compilation of the information on Form No. 16 as applied to the whole institution.

FORM No. 15

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF RÖNTGEN-RAY DEPARTMENT

Month ended.....19....

[8½ x 11 inches]

Services	Name of Physician or Surgeon	Patients	Plates	
First Surgical				
Second Surgical				
Third Surgical				
Fourth Surgical				
First Medical				
Second Medical				
Third Medical				
Fourth Medical				
Out-Patient Department				
Tuberculosis				
Maternity				
Children's				
Total				

CONDITIONS EXAMINED

Circulation	Respiratory	Gastric	Urinary	Joint	Bone	Fracture	Dislocation	Foreign Bodies	Pregnancy	Total Patients	Total Plates

To be made up monthly in the Röntgen-Ray Department and sent to the General Medical Superintendent.

FORM No. 16

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

CENSUS RETURNS FOR WARD.....SERVICE..... NUMBER OF BEDS.....

Date.....19....

[8½ x 11 inches]

REMAINING FROM PRECEDING DAY				Male	Female	Total
Men.....	Women.....	Boys.....	Girls.....			
ADMITTED DURING DAY						
Men..... (Give names below)	Women..... (Give names below)	Boys..... (Give names below)	Girls..... (Give names below)			
DISCHARGED DURING DAY						
Men..... (Give names below)	Women..... (Give names below)	Boys..... (Give names below)	Girls..... (Give names below)			
REMAINING AT END OF DAY						
Men.....	Women.....	Boys.....	Girls.....			

.....Nurse

This report to be made out as of midnight and taken up by the night supervisor. Report is to be sent to the Information Office. Transfers from ward to ward indicated by "T." Deaths indicated by "D." Discharged improved by "I." Discharged unimproved by "U." Discharged cured by "C."

FORM No. 17

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

DAILY CENSUS SHEET

[8½ x 11 inches]

Date.....19....

Wards	Beds	Patients	Vacancies	Admitted (check as admitted)	Transferred to	Discharged (check as discharged)	Died	Transferred from	Remaining	Wards	Beds	Patients	Vacancies	Admitted (check as admitted)	Transferred to	Discharged (check as discharged)	Died	Transferred from	Remaining
List wards according to services.																			

Remaining Males.....
Remaining Females.....
Total.....

Remaining..... Admitted..... Discharged..... Died.....
Remaining Males..... Remaining Females..... Total.....

Report of Assignment of Nurses

At the present time no report is made by the Superintendent of the Training School for Nurses as to the assignment of nurses and the number on duty in the various departments daily. It seems highly desirable that the Superintendent should have in hand such a record. At the present time it is not deemed advisable to have such a report made daily to the Superintendent of the Hospital. Form No. 18 (opposite) provides for a monthly report which will be based upon similar information recorded daily in the office of the Superintendent of the Training School.

Report of the School for Midwives

At the present time the School for Midwives makes no periodic report to the Superintendent of the Hospital except the information compiled for the annual report. It seems advisable that the Superintendent should be informed at shorter intervals of the operation of the School. Form No. 19 is provided for this purpose.

FORM NO. 19

BELLEVUE AND ALLIED HOSPITALS
BELLEVUE HOSPITAL
SCHOOL FOR MIDWIVES

Month ended.....19....

[5½ x 8½ inches]

	Males	Females	Total
Patients remaining first of month			
Babies remaining first of month			
Patients admitted during month			
Babies admitted during month			
Births			
Stillbirths			
Total during month			
Deaths of mothers			
Deaths of babies			
Stillbirths			
Mothers discharged			
Babies discharged			
Patients remaining end of month			
Babies remaining end of month			
Total during month			

Record of Attendance

Record of Attendance of Internes

At the present time there is no check upon the time rendered by internes or the regularity of their work in the wards. It seems advisable that the attending staff, and also the Superintendent of the Hospital, should be fully informed as to the service rendered by the internes. Form No. 20 is designed to accomplish this purpose. It should be a loose-leaf, with perforations, made in tablet form; a sheet to be filled out each day and signed by the Resident, and subsequently transmitted to the Chief of the service and then to the Superintendent of the Hospital.

FORM No. 20

Report of Assignment of Nurses

At the present time no report is made by the Superintendent of the

FORM No. 20

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

STAFF REGISTER

To be used by the residents and internes in each service.
Record times of going on and off duty each day.

Date.....19....

[8½ x 11 inches]

PLEASE USE SPACE IN ORDER OF COMING ON DUTY

Names	A. M.		P. M.		Emergency Calls
	On Duty	Off Duty	On Duty	Off Duty	

This certifies that I have examined the above register.

.....Resident

COMMENTS.

.....
.....
.....
.....
.....

Record of Leaves of Absence

A form is now in use in Bellevue Hospital providing for leaves of absence of internes. On the reorganization of the medical service such form would necessarily need to be changed. Form No. 21 provides for such change. A modification, for the like purpose, is submitted in Form No. 22, for use in the Out-Patient Department, to be used in connection with absences of the attending staff of the Out-Patient Department.

FORM No. 21

BELLEVUE AND ALLIED HOSPITALS
BELLEVUE HOSPITAL

Date.....19....

To the PRESIDENT, BOARD OF TRUSTEES,
BELLEVUE AND ALLIED HOSPITALS.

Dear Sir:

I respectfully apply for a leave of absence of.....days from my duties as.....on the staff of BELLEVUE HOSPITAL, beginning on the.....of.....19....

I recommend as substitute, subject to your approval, Dr. .....
.....

Very respectfully,

.....

Approved..... Chief of Division
Approved..... General Medical Supt.

DATA IN REGARD TO SUBSTITUTE

Dr. ..... is a graduate of .....
Experience.....
.....
Reference.....
.....
.....

[8½ x 11 inches]

FORM No. 22

BELLEVUE AND ALLIED HOSPITALS
BELLEVUE HOSPITAL

Date.....19....

To the BOARD OF TRUSTEES,
BELLEVUE AND ALLIED HOSPITALS.

Gentlemen:

I respectfully apply for a leave of absence from my duties as.....
.....in the.....clinic of the Out-Patient Department of BELLEVUE HOSPITAL, to begin on the.....day of .....19...., and to end on the .....day of .....19....

During my absence my service will be attended to by Dr.....

Respectfully,

.....M. D.

Approved..... Chief of Service
Approved..... Chief of Clinic
Approved..... General Medical Superintendent

Notice sent.....19....

.....Secretary

[8½ x 11 inches]

Patients' Clothing

The record forms now in use in Bellevue Hospital in connection with the care of the clothing of patients do not clearly establish the ownership of the various articles of clothing. The records have been faulty in connection with the accounting for clothing, both as to the delivery of such clothing to friends or to patients, and as to the condemnation of clothing when uncalled for. At present the man in charge of the clothing does not get a full receipt for the delivery, and so, while all the clothing has been delivered, the receipt does not clearly establish that fact. Forms Nos. 23, 24, 25, and 26 were designed to overcome these difficulties.

Laundry Accounting

At the present time no accurate account is rendered by the laundry of the work done in the laundry day by day. Upon request of the Superintendent an estimate is made of the amount of work done in the laundry during a given period. This estimate is made by counting the amount done on a particular day and multiplying it by the days in the period for which a report is to be made. It seems highly advisable that an accurate account should be made by the laundry of all work done day by day, as otherwise it would be impossible to determine who might be responsible for shortages.

At the present time no accounting of articles sent out of the wards to the laundry is made, which in case of the loss of any such articles makes it impossible to place responsibility for such loss. Forms Nos. 27, 28, and 29 were designed to account for the laundry work from the time of leaving the ward until the time it is returned to the ward. The method of using these forms would be as follows:

Form No. 27, printed upon durable paper, would be made out by the nurse for the ward. The account registered in the first column would be checked by the person in charge of the central linen room and the items then listed in the second column. The issue for the ward would be listed in the third column, and the totals for each carried forward into the last three columns. This form would remain in the laundry and become the basis for the monthly report provided in Form No. 29.

Form No. 28, private laundry list, would be used in the same manner.

Reports on Long Term Patients

From time to time cases are retained in the psychopathic wards longer than the law provides for and no report of such cases is now made to the Superintendent of the Hospital. Form No. 30 provides a report which will make these cases a matter of record.

At present only cases that have been in the Hospital three months are reported to the Superintendent of the Hospital as long term medical or surgical cases, and no report of patients having been readmitted several times for the same ailment is made. Form No. 31 is designed to take care of these cases.

FORM No. 23

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

RECORD OF CLOTHES AND VALUABLES

Listed in Admitting Baths.

FORM No. 24

Admitted to Ward No.....
Patient.....
Clothes Room No. Address.....
Date.....19....

Valuables	Clothing	
	Hat	Shawl
	Cap	Cape
	Coat	Dress
	Overcoat	Wrapper
	Vest	Waist
	Trousers	Skirt
	Sweater	Petticoat
	Undervest	Chemise
	Shirt	Nightdress
	Drawers	Corset
	Suspenders	Corset Cover
	Hose	Bonnet
	Garters	Veil
	Shoes	Blankets
	Collar	Crutches
	Tie	Cane
	Gloves	Umbrella
	Handkerchief	Valise

(Perforate and fold page on this line.)

(The reverse of this space is to be ruled and printed as a duplicate of the right half of form No. 23, so that it may bear a carbon copy of the name, etc., and clothes list. This form is to be detached and fastened to the clothing.)

Size 8½ x 11 inches, with margin for loose leaf binder and 3-inch margin to fold back for clothes slip.

FORM No. 25

O

Ward.....
Name of Patient

.....

Clothes Room No.....

Date.....19.....

.....
Nurse

Articles not in bag

.....

Patient's Receipt.

Received from Bellevue Hospital all articles of clothing deposited at time of admission.

.....
Patient

[3¼ × 6¼ inches]

FORM No. 26

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

LIST OF UNCLAIMED CLOTHING SENT FROM PATIENTS' CLOTHES ROOM TO HOUSEKEEPER FOR DISPOSAL

Date.....19....

[8½ x 11 inches]

Clothes Room Number	✓	Name of Patient	Condemned (To be checked by the condemnation officer)	Sent to Social Service Bureau	Remarks

....

In charge Clothes Room Condemnation Officer

This list to be made out weekly and, after being checked by the condemnation officer, to be filed in a binder in the Clothes Room.

Notification Slips Pertaining to Patients

The control of discharges and transfers is not at present vested in the Chief of a service. In the form now used it is provided that the house officer may sign the order for discharge or transfer. Form No. 32 provides for the signature of the Chief and approval of the Superintendent.

At the present time there is no provision for any clinical data to be sent from one hospital to another, and Form No. 33 has been devised for the benefit of the hospital to which a patient has been transferred.

At the present time when a patient is discharged and referred to the Out-Patient Department there is no form used to give the Out-Patient Department sufficient data for the continuance of the treatment. Form No. 34 is to be filled out by the Resident and sent to the Out-Patient Department. Form No. 35, which contains no medical data, is to be given to the patient and taken by him to the Out-Patient Department.

It seems wise that the Superintendent should be given information as to the cases showing sepsis, either before or after operation, and for this purpose Form No. 36 is to be made out by the Resident and sent to the Superintendent each month.

In all hospitals rules are established with regard to the giving of baths and care of hair of patients in the wards, and yet, in a great many cases,

complaints arise in regard to the condition of patients in this respect. Form No. 37 gives the Superintendent a record of what is done in the wards, so that it may be referred to in adjusting complaints.

It is the present practice for the nurse to notify the Superintendent by telephone in regard to cases of dangerous illness or deaths. Forms Nos. 38 and 39 make these matters of record, and should be sent to the desk of the Superintendent as confirming the telephone messages.

FORM No. 27

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

LAUNDRY LIST

Week ended.....19....

Pavilion..... Ward.....

[About 11 x 11 inches]

ARTICLES	Sent to Laundry during Week (Enter items when sent)	Received from Ward during Week (Check items when received)	Issued from Central Linen Room during Week (Enter items when issued)	Total Sent to Laundry during Week	Total Received from Ward during Week	Total Issued from Linen Room during Week
Bedspreads Blankets, single Blankets, double Pillow cases Sheets Curtains Tablecloths Towels Tidies Aprons Dresses Stockings Etc.						
	Counted by ..... Head Nurse	Checked by ..... In charge Linen Room	Issued by ..... In charge Linen Room			

This form to be printed on cardboard. To be made out by nurse in charge of ward and returned by Linen Room at end of week.

FORM No. 28

BELLEVUE AND ALLIED HOSPITALS
BELLEVUE HOSPITAL
PRIVATE LAUNDRY LIST

Name.....
Mark.....
Room No. .....

[5½ x 8½ inches]

	Sent	Received at Laundry	Returned
Trousers			
Coats			
Shirts			
Soft shirts			
Undershirts			
Drawers			
Union suits			
Nightshirts			
Pajamas			
Collars			
Cuffs			
Ties			
Handkerchiefs			
Hose			
Vests			
Washcloths			
Total pieces			

FORM No. 29

BELLEVUE AND ALLIED HOSPITALS
BELLEVUE HOSPITAL
MONTHLY REPORT OF WORK DONE IN LAUNDRY

Month ended.....19....

[5½ x 8½ inches]

	Flat Work	Ironed	Starched and Ironed	Total
Wards &c.				

This report to be compiled from the weekly laundry lists.
Attach to this the monthly report of supplies and equipment.

FORM No. 30

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF PSYCHOPATHIC CASES REMAINING LONGER THAN 10 DAYS IN HOSPITAL

Date.....19....

[8½ x 11 inches]

Names of Patients	Diagnoses	Condition	Dates of Admission	Dates of Discharge	Reasons for Retaining

Comments

.....Resident

FORM No. 31

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

SERVICE.....WARD.....

REPORT OF PATIENTS HAVING HAD 90 DAYS TREATMENT WITHIN 12 MONTHS PREVIOUS

Date.....19....

[8½ x 11 inches]

Names of Patients	Diagnoses	Condition	Dates of Admission	Dates of Discharge	Reasons for Returning

Comments

Signed.....Resident

FORM No. 32

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

Date.....19....

REGISTRAR:

You will kindly notify the friends of the following patients that they will be transferred to one of the hospitals of the Department of Public Charities, as they are in a physical condition to stand transferring:

Ward..... Name.....

Ward..... Name.....

.....
Chief Physician-Surgeon

Approved.....Superintendent

N. B.: These slips are to be signed by the Chief of the Division only.
(Slips similar to the above are now in use.)

[8½ x 11 inches]

FORM No. 33

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

TRANSFER SLIP Date.....19....

Name..... Sex..... Age.....M. S. W.

Last Residence..... Nativity (State or Country).....(Citizen Alien)

(If a widow) Was husband a citizen?.....(If unmarried woman) Was father a citizen?....

Occupation..... Education..... Religion.....

Name of father..... Birthplace.....

Name of mother..... Birthplace.....

Name of friend..... Address.....

Name of friend ..... Address.....

Diagnosis..... Condition.....

Medical treatment.....

.....

.....

.....

In cases of accident give time, place, and circumstances.....

.....

.....Resident

.....Chief

This history slip fully filled out should be sent with the patient when transferred.

[5½ x 8½ inches]

FORM No. 34

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

M..... Address.....

was treated in the Dressing Office at.....A. M. / P. M. .....19....

and referred to the Out-Patient Department.

Injuries: .....

.....

.....

Treatment given: .....

.....

Approved..... Signed.....

Superintendent Resident

(This form must be made out and sent to the Main Office for approval. It will be sent to the Out-Patient Department and filed there with the patient's history.)

[8½ x 11 inches]

FORM No. 35

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

DRESSING OFFICE

M..... Address.....

was treated in the Dressing Office at.....A. M. / P. M. .....19....

and referred to the Out-Patient Department.

READ THIS: Come to the Out-Patient Department and show this card at.....

o'clock.....A. M. / P. M. .....19....

(This form to be torn off from above and given to patient.)

FORM No. 36

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

To the General Medical Superintendent:

The following is a statement of the cases showing sepsis, either before or after operation as noted below.

Month ended.....19....

[8½ x 11 inches]

Ward	Names of Patients	Diagnoses	Sepsis Before Operations	Sepsis After Operations	Remarks

Number of operations ....Resident

FORM No. 37

BELLEVUE AND ALLIED HOSPITALS

BELLEVUE HOSPITAL

REPORT OF BATHS AND CARE OF HAIR OF PATIENTS IN WARD.....

Week ended.....19....

[8½ x 11 inches]

Number of Bed	Date	Number of Bed	Date	Number of Bed	Date

Patients are to receive a bath on entrance unless exception is made by the admitting physician.

Patients are to receive a cleansing bath once a week, and, in addition, as often as occasion requires. Feet must be bathed at least twice a week.

Patients' hair must receive "attention" on entrance, and also every week during their stay in the hospital, and oftener if occasion requires.

The nurse should enter upon this report "T" for tub bath; "B" for bed bath; and "H" for attention to hair.

Report to be sent to the General Medical Superintendent at end of week.

FORM No. 38

DANGEROUSLY ILL

Date.....19....

To the Superintendent:

Name.....

Ward.....Bed.....

Service of Dr. .....

Disease.....

Remarks.....

.....

.....

.....

.....

.....

.....

.....Resident

[3¼ x 4½ inches]

FORM No. 39

DEATH NOTICE

Date.....19....

To the Superintendent:

I beg to advise that

Name.....

who suffered from.....

in Ward.....died at.....

o'clock on the.....day of.....

19....

.....

....Resident

N. B.: This slip must be delivered to the office of the Superintendent upon verification of the death of every patient.

[3¼ x 4½ inches]

Section X.—SOME PROBLEMS AND REORGANIZATIONS

1. Proposed Reorganization of the Medical Service in Bellevue Hospital
2. Some Problems Common to all the Departments

I. PROPOSED REORGANIZATION OF THE MEDICAL SERVICE IN BELLEVUE HOSPITAL

FOREWORD

Bellevue Hospital has been justly renowned throughout the country as one of the leading general hospitals, and it has stood for work of high character. The investigation, however, has shown some weaknesses and shortcomings which seem to call for correction. The difficulties noted have been due primarily to too brief a time spent in the hospital by attending physicians or too frequent rotation of the personnel of the attending staff. The following memorandum sets forth this condition and recommends a plan of reorganization designed to overcome the difficulties and shortcomings noted.

MEDICAL AND SURGICAL SERVICES IN BELLEVUE HOSPITAL

Organization

So far as the care of patients is concerned, Bellevue Hospital consists practically of four hospitals. With the exception of certain specialized services, the Hospital is composed of four divisions; three of which are assigned to the following medical colleges: the First Division to the College of Physicians and Surgeons, a department of Columbia University; the Second Division to Cornell Medical School, a department of Cornell University; and the Third Division to New York and Bellevue Medical School, a department of New York University. The Fourth Division is known as an "Open Division," wherein physicians and surgeons may serve who are not attached to the faculty of any medical school. Some services are under the direct supervision of the Hospital, such as the Psychopathic and Alcoholic Services, the School for Midwives, the Tuberculosis Camp Boat, and the Pathological Department. The children's Medical Service is assigned to the First Division, and the Surgical Service for children is divided among the four Divisions. All except the First Division have a Gynecological Service. The four Divisions rotate through the Erysipelas and Tuberculosis Services.

Until April 8, 1913, the control of the Services was exercised by a Medical Board composed of about 40 members. On that date the Board of Trustees passed a resolution reconstructing the Executive Committee of the Medical Board, and gave it authority to have "supervision and executive control over the medical management of the Hospital." By this resolution the Executive Committee supplanted the Medical Board in so far as the management of the Medical Service is concerned. The Committee consists of one physician and one surgeon from each of the four Divisions and, *ex officio*, the General Medical Superintendent and the Director of Laboratories.

At this same meeting of the Trustees a resolution was adopted appointing the President of the Board of Trustees and the President of the Medical Board as a committee to confer with Mr. Henry S. Pritchett, of the Carnegie Foundation, "as to the appointment of an expert to advise the Board of Trustees in regard to a plan or policy of medical and teaching reorganization of the new Bellevue Hospital."

Your Committee had drafted a plan for the reorganization of the Medical Service in Bellevue, in March, 1913, and had entered into conferences with the President of the Bellevue Board, and the action of the Board of Trustees of the Hospital indicated that the Board recognized the advisability or necessity of some kind of a reorganization.

The Medical Board is in a large measure self-perpetuating, in that each Division makes nominations to fill vacancies, which nominations are submitted to and passed upon by the Medical Board and subsequently confirmed by the Trustees. In but one instance in recent years have they refused to accept the nomination made by the Medical Board.

Visiting Staff

The Visiting Staff of each Division is composed of Visiting, Assistant Visiting, and Adjunct Assistant Visiting Physicians and Surgeons, all serving without pay. Each Division has four Visiting Physicians, who rotate in periods of three months each during the year. These four men, representing a Division, nominate one or more Assistant Visiting, and Adjunct Assistant Visiting Physicians or Surgeons. The Assistant Visiting, and Adjunct Assistant Visiting Physicians and Surgeons not only assist the Visiting Physicians and Surgeons, but also serve in their absence. The amount of time to be given by the Visiting Staff is not specified by any regulation, but is supposed to be sufficient to insure proper medical and surgical care. When none of the members of the Visiting Staff are present in the Hospital the care of the patients devolves upon the House Staff.

The personnel of the staff of Visiting Physicians rarely changes; the same members, with few exceptions, have served the Hospital for many years.

House Staff

The House Staff is composed of graduate medical students. Each Division, except the Third, holds an open competitive examination. The Third Division limits the applicants to its examination to graduates of the New York and Bellevue Medical School. These examinations in former years were held late in spring, but, owing to competition between hospitals, they have been gradually pushed forward until at the present time they are usually held in February or March. This midwinter examination makes it very difficult for students from other parts of the country to be present in New York City for examination. The internes thus selected through examination are, both in theory and practice, officers of the Divisions, rather than of the Hospital itself. The Hospital has practically no control over the interne staff, except that they may be disciplined or discharged for gross misconduct. Almost the entire management and control of the interne staff rests in the hands of the Visiting Staff.

The function of the House Staff is to care for the patients under the direction of the Visiting Staff, and to have full charge in the absence of members of the Visiting Staff. Inasmuch as members of the Visiting Staff are present in the Hospital but a small portion of the 24 hours of the day, the major number of patients are admitted in their absence. These patients must be examined by the House Physician or Surgeon, and they are supposed to be subsequently examined by the Visiting Staff. The House Staff is responsible for keeping the medical records.

The House Physician or Surgeon is a senior interne, and serves in such position for 6 months after having served in the Hospital for a period of 18 months. The internes, at the time of examination, according to standing, are allowed to choose whether they shall serve for one year, 18 months, or two years, and it is understood that those who choose to serve two years will become House Physicians or Surgeons.

A junior interne is assigned to each ward, under the supervision of the Senior Resident, who exercises control over him and assigns certain duties to him. He takes clinical histories; performs the clinical laboratory work; looks after pus dressings in the Surgical Service; acts for his senior in his absence; and performs such other duties as may be assigned to him.

Admission of Patients

There are three Admitting Physicians paid by the City ($1,000 per annum). Two of these are on duty during the day, relieving each other at stated hours, and one is on duty all night. The tenure of office is indefinite. They are appointed by the Trustees and are selected from among house officers who have completed their term of service. They are at times assisted in their duties by members of the House Staff. The Admitting Physicians are on the staff of the Superintendent and at times are called upon to perform the routine duties of Assistant Superintendents.

All patients entering the Hospital, whether applying to the Admitting Physicians, referred from the Out-Patient Department, brought by ambulance, sent by members of the Visiting Staff, or transferred from other hospitals, pass through the admitting office, except insane patients, who are taken directly to the psychopathic ward and the necessary records made afterward.

The Admitting Physicians enter a preliminary history of the patients. The patients are then sent to the bathroom and subsequently to the wards to which the Admitting Physician has assigned them. In designating the ward to which a patient is to be sent the admitting office is governed by a rule requiring patients to be assigned in rotation to the four Divisions of the Hospital. This system of rotation does not apply to patients admitted during the night, the latter being assigned to wards with vacant beds. In other words, they are assigned in the discretion of the Admitting Physician on night duty. Patients bringing requests for admission from one of the Divisions of the Out-Patient Department or from a member of the Attending Staff are excepted from rotation, and sent to the Division from which the request emanated. These requests are sent to the Superintendent for approval before the patients are admitted.

No patients are rejected because of their financial status. Inquiry is made as to the earnings of applicants and a record made on the history card. Some of these cases are afterward questioned by the Hospital investigators, and sometimes the home conditions are investigated. The proportion of cases that pay for care in the Hospital is very small, so small as to be negligible.

Discharge of Patients

Under the rules of the Hospital, House Physicians and Surgeons may discharge responsible patients upon their own request; they may discharge irresponsible patients at the request of accredited friends, obtaining a signed release; they may discharge patients when directed by their respective Visiting Physicians or Visiting Surgeons. In all these cases it is provided that the form of discharge must be accepted by the Superintendent. As far as can be ascertained by inquiry the practice is for the Senior House Physician or Surgeon on duty in a given service to discharge patients, the form being sent to the Superintendent for signature. In some cases the Senior House Physician consults the Visiting Physician in regard to discharge. It is evident that the routine discharge of patients is controlled by the House Staff, the function of the Superintendent in this respect being merely formal and confined to the signature of the form; he is not required or authorized to determine the fitness of the patient for discharge. It will be noticed that the House Physicians and Surgeons have had but 18 months service previous to being intrusted with this function.

These internes are in the Hospital primarily for study and observation. They desire to see as many cases, and as many different kinds of cases, as possible. Prompted by this desire, their tendency is to discharge prematurely patients in whom they have little interest, and inasmuch as they are not responsible to the Hospital as an organization, this tendency is but little restrained. With these internes responsible only to the Visiting Staff, it would be very difficult for the Hospital to adopt and carry out any broad program of care and treatment. The policy of the Hospital with regard to the length of treatment is thus largely regulated by these inexperienced internes, who are looking for new and interesting cases.

The only class of patients whose stay in the Hospital the Superintendent of the Hospital regulates is the class of patients who have remained in the Hospital 3 months or longer. Each month a report is made to the Superintendent of the patients who have been in the institution 3 months, and, thereupon, an examination is made by the Superintendent or his assistants, and a decision is rendered as to whether such patients should remain or be discharged. This rule is adequate to regulate the maximum stay of patients, but the Hospital authorities seem to have little or no control over the minimum stay.

Results of the Existing System of Medical Service in Bellevue

It seemed desirable to ascertain, as far as possible, the results of the medical practice in Bellevue Hospital. It appeared highly inadvisable to attempt to secure the opinion or judgment of any physicians as to the results of the work of other physicians attached to the Bellevue staff, as such judgments would be difficult to secure, and when secured would be given little credence.

As a method of test it was decided to make an examination of the records in the Hospital in so far as such records might throw light upon the probable condition of patients on discharge and the attention that may have been given patients while in the Hospital. With this purpose in view, the records of all lower extremity fracture cases that had been discharged from Bellevue during the year 1912 were examined. The cases were tabulated under the following classifications: fracture of the ankle; femur; foot; leg; patella. The number of cases under each classification was recorded according to the length of time they had remained in the Hospital, being listed under those that stayed 1 day; 2 days; 3 days; 4 to 5 days; 6 to 7 days; 8 to 12 days; 13 to 21 days; 22 to 31 days; 32 to 61 days; 62 to 92 days; 93 to 123 days; 124 to 183 days; 184 to 365 days. By this method of tabulation it was easy to determine the percentage of cases that were discharged within a given time.

All cases readmitted one or more times during the year 1912 were examined and classified in various ways, to determine what proportion received a diagnosis on a subsequent admission differing from that recorded at a previous discharge. These readmissions were also classified on the basis of the incubation period for various diseases.

The homes of about one thousand patients discharged from Bellevue during 1912 were visited, to determine the apparent condition of patients on discharge and what happened to them subsequent to discharge; whether they recovered, and, if so, within what period; whether they received subsequent treatment by private physicians or by another hospital; or whether they re-

turned to Bellevue a second time. This inquiry also showed the condition of the homes into which patients were discharged; whether or not the home was a suitable place for a convalescing patient; and whether the financial status of the family was such as to enable them to support a member of the family unable to work.

The number of visits made by each member of the Visiting Staff and the time spent in the Hospital were taken from the records and tabulated so as to show the average time rendered to the patients by the staff of the different Divisions in the Hospital.

The records of Bellevue were examined for the year 1912, to determine the average length of stay of different classes of cases, and the results were tabulated according to the Divisions of the Hospital. These tabulations showed not only the average length of time patients stayed in the Hospital, but also the number discharged after remaining in the Hospital 1 day, 2 days, 3 days, etc. In order to examine these records it was necessary to make a complete transcript of nearly 20,000 cards and to examine fully 300,000 records.

It is probable that the conditions in Bellevue are not worse than in a large proportion of our good hospitals. If any of our high-class hospitals were examined in detail many things would be found which should be corrected, and which the attending physicians would readily admit should not have occurred. However, these facts, set forth in connection with those in Section III, have seemed to the Committee of such import as to warrant a recommendation for a rather radical reorganization of the medical service in Bellevue Hospital. The main conclusions arrived at from these facts may be summarized somewhat as follows:

1. The diagnosing of cases has been less thorough and less accurate than should have been expected, owing in part to insufficient time rendered to the Hospital by the attending physicians and in part to too great a trust in inexperienced internes.

2. A few of the attending physicians have been present at all autopsies pertaining to their respective Divisions, while most of them have attended but few autopsies, which fact indicates an insufficient interest in the accuracy or inaccuracy of their clinical diagnoses.

3. Internes have been permitted to discharge patients without the knowledge of the attending staff, and in many cases these patients were either not in proper condition to be discharged, or were discharged to homes unfit for their reception.

4. The internes have been primarily interested in seeing new and interesting cases, and, accordingly, have too often discharged cases which were uninteresting, though still in need of hospital treatment.

5. The Social Service Department of the Hospital has received notification of the discharge of comparatively few patients, and little coöperation exists between the discharging staff and the Social Service Department, with the result that little attempt has been made to gain information as to the condition of the homes into which patients are discharged.

6. Clinical histories and records have been so carelessly and inadequately kept that they have been of comparatively little service in the treatment of cases on the first or subsequent readmissions.

7. Owing to the comparatively small amount of time rendered to the Hospital by the attending physicians little scientific work has been done, and the pathological material has been but little used.

8. The system of rotating services for the Visiting Staff has militated against good treatment of patients.

9. The method of examining internes on entering the Hospital, by the college Divisions rather than by the Hospital, has made the internes feel that they are officers of the college Divisions rather than of the Hospital. This condition has made it difficult for the Hospital to carry out any consistent policy which might to some extent interfere with the interests of the internes.

10. The internes have not received the diagnostic training that they should have received, owing to the fact that they have been thrown too largely upon their own resources rather than guided by the attending staff.

Bellevue has offered a splendid opportunity for internes to practice, but to practice with too little guidance on the part of trained and competent physicians.

The primary object of Bellevue Hospital, as well as other hospitals, should be to properly and adequately care for the sick. Its form of organization, its methods of administration, its regulations should all be directed toward accomplishing efficiently this primary purpose.

After years of experience, it has been found that patients are better cared for in hospitals where teaching is done than in hospitals where none is carried on. The King Edward Hospital Fund Committee of London, appointed to investigate the relation of the hospitals to the medical colleges, after a searching and painstaking inquiry came to the unanimous conclusion that patients were much better cared for in hospitals wherein medical schools did teaching than in hospitals which were not served by such schools. It seems to be generally conceded that the medical service in Bellevue Hospital is improved by the attendance of a visiting staff largely selected from the medical colleges. The reciprocal relation existing between Bellevue and the medical colleges is of benefit both to the patients and to the colleges.

The City has the right to ask, however, not only whether patients are better treated because of the service rendered by the medical colleges, but also whether or not these schools at the same time are using the clinical material to the best advantage for the furtherance of medical education. Inasmuch as the City furnishes and maintains an expensive hospital plant, wherein is one of the best equipped pathological laboratories of the world, it is just that any medical college having the privilege of serving therein should be required to use the facilities to the very best advantage. That the medical colleges have not improved these advantages as they might have done is readily apparent. The attending physicians, most of whom are instructors in the medical colleges, have not rendered the amount of time in the Hospital necessary to properly instruct the students in diagnosing cases; they have not experimented sufficiently as to means of alleviating or curing disease; they have not made the close scientific study of the causes of disease that should have been made. Inasmuch as knowledge as to the causes and progress of disease will tend to preserve and guard the health of all citizens, New York City should so operate its hospitals that the sick cared for therein shall add to medical knowledge.

Prompted by the fact that the medical service in Bellevue Hospital is inadequate, and that the opportunities for study offered by the large number of patients and the expensive equipment are not being adequately utilized, the Committee has deemed it advisable to recommend a radical reorganization of the medical service. The Committee recognizes that the physicians

and surgeons who have given their time voluntarily have rendered a great service to the sick of the City, and it is regretted that it seems necessary to suggest a reorganization which will result in subordinating many of these men to a paid chief, should they continue to serve in the Hospital. It is believed, however, that most of these men appreciate the fact that physicians and surgeons burdened with a large private practice cannot give the time required to promote the best interest of the patients and the most rapid advancement of medical education. They recognize that there must be directing heads to the Services who can devote a large portion of their time to close clinical and scientific work in the Hospital.

The recommendations of the Committee with regard to the reorganization of the medical service in Bellevue are as follows:

Plan of Reorganization

1. Control to remain in a Board of Trustees, to which shall be delegated power to determine general matters and policies. Such Board to appoint a Superintendent for a prescribed period of years, who shall have full administrative control of the Hospital and Out-Patient Department.

2. Control of admissions, distribution, discharges, and social service to be under the charge of the Superintendent.

3. Present Medical Board to be supplanted by an Advisory Committee constituted as follows; the Chiefs of the Medical Services, the Chiefs of the Surgical Services, the Director of Laboratories, and the Superintendent: such Committee to have no power other than advisory. (Four Medical and four Surgical Services representing three medical colleges and one open Division.)

4. The Out-Patient Department to be an integral part of the Hospital, both from an administrative and a medical standpoint; the medical and surgical attendants of each Division of the Out-Patient Department to be appointed by the Trustees on nomination by the medical and surgical Chiefs of the respective Divisions of the Hospital and the Advisory Committee.

5. Each medical school to be required to furnish a continuous service by means of a paid Chief of its Medical and also of its Surgical Service; such Chiefs to be paid in part by the medical schools, the City to pay one-half of the salary when such half does not exceed $2,500 per year; heads of the Fourth Division to be nominated by the Council of the Academy of Medicine and the entire salary paid by the City; such Chiefs to be appointed for a term of years and to serve in the Hospital, on an average, not less than one-half of each day; an age of retirement to be established; a service of attending physicians and surgeons associated with such Chiefs to be provided for; nominations of the attending staff for each Division to be made by the respective Chiefs of such Divisions and by the Advisory Committee; special services to be assigned to the various Divisions for designated periods, with some possible exceptions; all nominations to be submitted to the Board of Trustees for approval.

6. A Resident Physician for the Medical Service and a Resident Surgeon for the Surgical Service of each Division to be employed; one-half of the salary of such Residents to be paid by the City and one-half by the respective medical schools; appointments for such positions to be made for a specified term by the Trustees on nomination by the Chiefs of the respective Services and the Advisory Committee.

7. Internes to be nominated by the Advisory Committee, after an examination held by the Committee, the form of which to be approved by the Board of Trustees; the appointment to be made by the Trustees; the results of the examination to be made a matter of record.

8. The Trustees to reserve the power to discontinue, for cause, the services of any medical officer, chief of service, resident or attendant physician, surgeon, pathologist, or interne, whether paid or unpaid; if paid, whether paid by a college or by the Hospital or partly by both.

9. In the Pathological Department, the salary of the Director of Laboratories to be paid by the City; his functions and duties to be as follows:

   (a) To have general supervision of all laboratories connected with the Hospital and all the work carried on therein.
   (b) To keep all records of findings.
   (c) To perform or control the performance of all autopsies.
   (d) To control the use of all organs and tissues.
   (e) To direct the work of the pathologists assigned by the colleges.

Each college Division to nominate a Pathologist whose appointment shall be subject to the approval of the Director of Laboratories and the Trustees of the Hospital; the salary of such Pathologists to be paid by the respective colleges, and to be not less than $1,500 per year; the entire time of these Pathologists to be devoted to work at the Hospital; the amount of teaching and research work to be carried on to be regulated by the respective colleges, subject, however, to necessary routine work assigned by the Director of Laboratories.

Argument in Support of the Plan of Reorganization

1. Control to Remain in a Board of Trustees

A single head, when competent, is always more efficient than a directing board. A board cannot be a successful administrative body. Could we be assured of the selection by each succeeding Mayor of a competent commissioner for Bellevue and Allied Hospitals, a board of trustees should not be given consideration. The Bellevue Board of Trustees has been but partially successful, as shown by the investigation of this Committee. It has, however, raised the standard of hospital practice in a noteworthy degree, but greater efficiency would have resulted had it confined itself to a determination of general policies and measures and held the Superintendent strictly responsible for results. It has established very few forms of reports designed to give information as to the success or failure of the various functions performed in the Hospitals. The shortcomings noted in Bellevue are attributa-

ble to the above causes and not to causes inherent in a board of trustees as such.

Boards of trustees as governing boards of large corporations are a success. A board of trustees can be a successful controlling body for Bellevue and Allied Hospitals if it will control as do the corporation boards; viz., by confining itself to appointments, policies, and measures, and by requiring reports which will inform as to results.

If the Department of Bellevue and Allied Hospitals is to remain a separate department it is perhaps advisable to continue the Board of Trustees, but with restricted powers.

2. Control of Admissions, Distribution, Discharges, and Social Service

The Superintendent nominally controls admissions through admitting officers employed by the Hospital. In practice this control is but partial, for the discharges are in the hands of the House Staff, and in seasons when there is pressure upon the service patients are assigned to the Services which have the most vacancies. Many vacancies are made by premature discharges, so that the admissions are in a degree regulated by the discharges made by the House Staff.

There have been no transfers between Divisions. Many vacant beds have at times existed in one Division when another was overcrowded, and there have been no transfers from Surgical to Medical Service for better adjustment.

All of these matters should be controlled by the Superintendent.

3. Advisory Committee to be Established for Medical Board

The powers of the Medical Board recognized by the City Charter were transferred in 1913 to an Executive Committee. The functions of the Executive Committee as now constituted are similar to those of the proposed Advisory Committee.

4. The Out-Patient Department to be an Integral Part of the Hospital

That about 25 per cent. of the patients admitted to the Hospital remain less than 72 hours argues that a large number of patients now admitted to the Hospital could be cared for in the Out-Patient Department, were it properly correlated with the Hospital. It should be possible for a physician of the Out-Patient Department to place a patient in the Hospital for diagnosis under his own direction, but at present this is done in a very limited degree. Little argument is needed to support the need for such correlation.

5. Medical Schools to Provide Paid Chiefs of Services

Diagnosing to-day is a process much more complicated than in the days when judgment was based chiefly on pulse, temperature, tongue, color, etc. The diagnostician must make, or have made, various blood and secretion tests, which involve time, technical knowledge, and skill. More time is given to patients, resulting in a larger percentage of correct diagnoses than formerly. We are demanding for the patients in our City hospitals as good care and treatment as are given to private patients, which was not the case some years ago. These changed conditions demand from the staffs of municipal hospitals much time, but the time thus given by the attending

staffs limits the amount allowed for private practice. Owing to the necessity of spending more time with the patients in the hospitals the number of attending physicians has been increased so as to require but a reasonable amount of time from each. The increase in the number on the staffs has scattered responsibility, not only as between a number of rotating visiting and assistant visiting physicians, but also as between these heads and the house staffs. Treatment begun under one head may be transferred in turn to two or more physicians before the termination of the case.

Good work cannot be done without centering responsibility upon one man who is able to give sufficient time to supervise processes and check results. The amount of time thus required cannot be given by a physician who must secure his living by maintaining a private practice. More time must be given than has been given, and when rendered should be paid for.

The medical profession in Germany has advanced beyond the profession in this country in diagnosing. This advance in Germany is largely attributable to the paid chiefs of services in the state and municipal hospitals. A description of this paid service is fully set forth in "Medical Education in Europe," by Abraham Flexner. Opinions of leading physicians in this country with regard to a paid service will be found in the appendix on pages 741 to 759. The experience in Germany and in Johns Hopkins Hospital, and the opinions of leading physicians referred to, all point to the advisability of a paid service.

However, the plan for Bellevue Hospital as proposed by this Committee provides that the salaries of the Chiefs shall be not less than $5,000, half of which, but not exceeding $2,500, to be paid by the City.

In the opinion of many of those most competent to speak this salary will secure half of the time of the most competent physicians and surgeons. Half of the time of the Chiefs may be devoted to consultation practice, which will give them a larger experience with the early stages of diseases not usually found in hospitals.

As long as the Fourth Division exists it will be necessary for the City to pay the full salary of the Chiefs. However, there appear to be some good reasons for abolishing this Division, but this action is not recommended at the present time.

6. Provision for Resident Physicians and Surgeons

Many of the shortcomings in our hospitals are attributable to the comparatively inexperienced house physicians and surgeons. These men, who are in sole charge of the patients in the absence of the chiefs, should be experienced men. Moreover, the Chiefs should have assistants whom they can trust to carry out instructions intelligently and accurately. To secure these conditions paid men are necessary. So few will disagree with this provision that little argument is needed.

7. Internes to be Officers of the Hospital Rather than the College Division

Few will dissent from the contention that the internes should be chosen for the whole Hospital by one examination, and that when chosen they should represent the Hospital management rather than the colleges. The internes may be more nearly classed with the nursing staff than with the medical service. According to the proposed plan the medical and surgi-

cal treatment is delegated by the Hospital to the colleges. The nursing or care of the patients is retained under the supervision of the Hospital. Since the Hospital is and must remain responsible for the proper care of the patients, the internes, as a part of the nursing service, should be responsible primarily to the Hospital.

8. The Trustees to Discharge for Cause

The City must retain full control of its hospitals, and cannot do so without reserving the right to discharge any officer who may not measure up to the standards set by the hospitals.

9. The Pathological Department

The Pathological Department performs several functions: first, by autopsies it checks the accuracy of the clinical diagnoses of the physicians —this function of the Department must be under the control of the Hospital; second, it may do work required in connection with clinical diagnosing—this is primarily work of the colleges; third, it may do work of original investigation—this may be work of the colleges or of the Hospital, according to the policy of the Hospital. The functions which are or may be performed by the Pathological Department are not possible of clear definition at the present time, except in so far as they apply to autopsies. These clearly must be controlled by the Hospital. Likewise the tissues, as a part of the bodies to be conserved, must be controlled by the Hospital. The Pathological Department, in so far as it deals with bodies or tissues, must be under the control of the Hospital. This condition makes it necessary that all officers in the Pathological Department should be under the control of the Director of Laboratories. Inasmuch as the colleges desire to do teaching of gross pathology in connection with autopsies, it seems reasonable that each should furnish and pay the salary of such teacher and demonstrator.

APPENDIX

TO

PROPOSED REORGANIZATION OF THE MEDICAL SERVICE IN BELLEVUE HOSPITAL

During the process of formulating a plan for the reorganization of the medical service of Bellevue Hospital many local physicians were consulted, and the tentative drafts were modified many times as a result of these conferences. After the plan had reached about the form in which it is now presented it was sent to some of the leading physicians throughout the country for further expression of opinion, and as a result of these opinions some minor modifications were made. The letters of these eminent physicians are deemed worthy of record and are set forth in part herewith.

Letter Transmitting to Physicians Tentative Draft of Plan

Dear Dr. ———.

I take the liberty of sending you a draft of a suggested reorganization of the medical service of Bellevue Hospital, of this City. It was drafted by this Committee after consultation with a number of the leading medical men of the country, and we desire to secure some further opinions with regard to the advisability of substituting some such form of reorganization for the plan of voluntary and rotating service now in operation. I shall highly appreciate it if you will express your opinion with regard to the plan. If agreeable, will you please cover the following points in your reply:

1. Do you consider a paid service preferable to a voluntary service, and if so, why?
2. Does the plan provide an acceptable means of securing a paid service?
3. Do you consider the proportions of the salaries of the Chiefs of the Services provided in the plan fair both to the colleges serving in the Hospital and also to the City?
4. What objections do you find to the plan as outlined?

I shall be glad to have you express your opinion on the plan, without regard to local conditions at Bellevue Hospital, and without regard to consideration as to whether or not the present is an opportune time for putting it into operation.

I shall consider it a great favor if you will give us your opinion and also permit us to quote it if it seems to us advisable.

Sincerely yours,

HENRY C. WRIGHT,

Director of Investigation

Extracts from Letters

(Written in the month of December, 1913)

Dr. Charles H. Frazier
Philadelphia

1. I believe that hospitals should give some money compensation for service rendered, not that it will obtain in this way a higher grade or a better physician, but it enables the hospital to demand more time of the attending staff than it is justified in doing when services rendered are purely voluntary.

2. The general plan of concentrating the responsibility of the several services of the Hospital in the hands of a few, and more particularly of affording to the staff a continuous service throughout the year, is an excellent one and calls for nothing but meritorious comment. I see no reason why under the plan you have proposed you should not obtain a group of capable men between the ages of thirty-five and forty who would be only too glad to give half of their day to the Hospital with adequate compensation and ample time for private practice.

3. The salary question is a more difficult one, and perhaps there are conditions in New York with reference to the relation of the hospital to the school with which I am not familiar. I believe, however, that in course of time you will find that the salaries will, and ought to, be paid altogether by the City.

4. I have no objections to the plan as outlined, and I am delighted to know that it will soon be put in operation. I happen to have been responsible for the adoption of a similar plan on a very small scale at the Episcopal Hospital in Philadelphia, where we reorganized the out-patient department and have on duty two salaried physicians, with necessary assistants throughout the year.

Dr. Frank Billings
Chicago

I consider a paid service in a hospital preferable to a volunteer service. I believe this to afford better service to the hospital because a paid service must necessarily imply a required daily attendance of the physician and surgeon at a fixed time. Under no other conditions, probably, would an adequate time service be given.

The salaries of chiefs of staff need not be large and the sum named in the outline of the plan submitted is, I think, sufficiently large as the salary of chiefs of departments. For associates and assistant attending physicians and surgeons I think the salary paid should be sufficient to interest these attendants, and it need not be a large sum.

Second: I think the plan provides an acceptable means of securing a paid service. The plan as I understand it is that the medical schools of New York shall have three Divisions of the Medical Service and three Divisions of the Surgical Service, which will afford an opportunity to use the Hospital as a teaching institution, a service which is absolutely necessary provided the medical management remains at a high standard.

Third: I cannot answer the third question as to whether the plan provided for the payment of the salaries by the colleges and by the City is fair and equable.

The medical service in a hospital is for the benefit of patients, and, therefore, if properly administered is a service entirely for a city. The fact that the medical schools have the privilege of using the Hospital as a part of their teaching facilities does not necessarily mean that the medical schools should pay any part of the salary, for I believe that the service is made so much better by the fact that the Hospital is a teaching institution that it is a real economy to the City. In other words, I think it pays the City to permit the medical schools to use Bellevue Hospital, for by so doing the patients are more thoroughly examined, and better managed than they would be if there was not the constant inspection and criticism offered by the presence of students. This probably also means a shorter stay in the Hospital of many patients and a real economy to the City.

At the same time, if the medical schools agree to enter into a plan by which they shall pay half the salaries there can be no objection to it.

Fourth: I do not know that I have any objections to make to the plan outlined, excepting in paragraph eight, where the statement is made that the Board of Trustees reserves the power to discontinue the service of any medical officer. Without making any modification of that phrase should there not be inserted the phrase "for cause"? Would it not be unfair to permit the Board of Trustees full power to remove an attendant without cause? Would not that power be abused at times?

DR. ALEXANDER MCPHEDRAN
Toronto

1. A paid Service should be very much more efficient than a voluntary one, since it would require a higher degree of efficiency and a closer attention than you can usually get from voluntary service. I fear, however, that the salary suggested is not enough to secure the strongest men available. But it is a striking advance on the past that you should contemplate undertaking such an improved organization.

2. The plan you suggest seems to provide an acceptable means of securing a paid service of the character you contemplate.

3. The proportions of salaries of Chiefs seem fairly divided between the colleges and the City.

4. I am somewhat diffident in offering the objections that occur to me and I hope you will receive them in the spirit in which they are offered—a desire to promote medical science. The chief objection I see to it is the division of the Hospital into so many sections, making, in fact, four independent hospitals so far as the staff is concerned. If you could manage to consolidate the whole into one under the direction of one of your colleges you should secure a very much better result. You have plenty of hospitals in New York to place at the disposal of each university a large hospital for its own clinical purposes. It is a well known fact that the teaching hospital is much the more efficient one. It is probably well within the mark to say that no hospital which does not afford teaching facilities is of the highest standard. Why should not then a conference be held between the various universities and the chief hospitals to arrange for placing one of the large hospitals at the disposal of each university? It is only in this way that you can get the best care of the patient and at the same time promote the scientific advance of medicine. New York owes it to itself and to the country to make it one of the centers in the world of scientific medical education. It now has probably the best research institute in the world and why should it not also have the best training institutions for undergraduates in medicine? There should not be an insuperable difficulty to consummating such an arrangement. Under such an arrangement the head of the department of medicine and that of surgery should devote nearly the whole of his time to the Hospital interests, not allowing probably more than an hour or two a day for private consultations. They should be aided by a vigorous, well-trained staff of young men who will devote their whole time to the Hospital and research work under the Chief's direction. No doubt the Chief would need one or more senior men as assistants who would give nearly their whole time to the Hospital. To my mind this is the plan that offers the best results for the Hospital and those who are treated in it, as well as for the education of the undergraduate, and also the promotion of research investigation.

I would suggest that in paragraph three of your draft the Advisory Committee should be given more power. Removals and appointments should only be on their recommendation. If the Trustees do not approve the recommendation they should return it with a request for further consideration. The Advisory Committee is in the best position to understand the requirements of the Hospital.

4. Should not the out-patient clinic be organized as separate units for medicine and for surgery with directors coördinate with the Chiefs of the indoor services in charge?

5. Why make an age limit? Some men are more efficient at seventy than others are at fifty. Why should not efficiency be the limit? It is so in Germany, a country in which perhaps the most advanced work so far is being done.

7. As examination is a poor standard to judge qualification, would it not be better to accept the recommendations from the heads of institutions from whom you would be willing to accept candidates for the indoor staff, the recommendations to state not only the academic qualifications but also personal fitness? The institutions so favored would recognize the necessity of recommending only capable men; that, I think, would be sufficient in securing an efficient indoor staff, and, in that way, safer than you would be by examination.

9. Each service, I presume, will have its own clinical laboratory. Should not that laboratory be under direction of the head of the service and not under the Pathological Department, although the coöperation of the Pathological Department should be secured? If the Director of Laboratories is only a hospital officer is it certain that there would be coöperation between him and the college pathologists whose work the Director is to supervise? I suppose the college pathologist will be a resident in the Hospital.

DR. RUFUS COLE, Director
The Hospital of the Rockefeller Institute for Medical Research
New York

I take pleasure in replying to your letter of December 16th requesting my opinion of the suggested plans for reorganization of the medical service of Bellevue Hospital. I do this with the understanding, stated in your letter, that my views have a general application and do not necessarily apply especially to the medical service at Bellevue, since I have too slight familiarity with conditions there to justify my making any specific recommendations. The suggestions I have to make apply especially to the medical service, since I have had no experience in the organization of a surgical clinic.

The plan as outlined by you seems to me to mark a very distinct and important advance in the present methods of organization of the medical service of general hospitals. The hospital can only demand efficient service from its attending staff when it gives something in return for service rendered. It is too much to expect that such a large part of the time of physicians as is required for efficient hospital service should be given from purely altruistic motives, a very much larger sacrifice for social service than is demanded from, or given by, men of any other profession or occupation. As a matter of fact, this service in the past has not been rendered purely for this reason, but has been given because recompense is obtained by the physician for the time spent: (1) through increased experience gained and so increased ability and power, and (2) through increased prestige gained both with the profession and the public. The first recompense is certainly legitimate and the desire for it praiseworthy; the second occupies a distinctly lower plane and, when allowed to become the main recompense for the service rendered, has led to the great abuses with which all are familiar. It should be entirely disregarded by both the hospital and the physician.

The organization and direction of a medical clinic require a very large amount of time, and it is doubtful whether a physician, depending for his income upon his practice, without any other financial recompense, could afford to devote to it sufficient time to obtain satisfactory results. Your plan provides that such work will require at least four hours per day. I should say that this is a low rather than a high estimate of the time required. The salary of $5,000 provided for the Chief of clinic should enable a man of the very best training and ability to give at least half his time to this work. The added recompense in the way of increased skill and knowledge would undoubtedly, with the fees at present obtained for the best service, enable such a man to make an income commensurate with that obtained by the best men in the other professions.

The provision made for a Resident Physician to give all his time and to act as assistant to the Chief of the clinic will enable the latter to most effectively employ the time at his disposal. The provision to pay the Resident Physician a small salary seems to me wise and just. With a Chief of clinic giving half his time, a Resident Physician of considerable experience giving his full time, and a staff of capable assistant attending physicians and of capable internes, a good clinic could be rather efficiently manned.

The attending physicians, under the plan proposed, are to receive no salaries. If they give only one or two hours a day to the work, it would seem that the recompense in the way of increased skill and knowledge would be quite sufficient, and that their incomes, instead of suffering from such time given, would be increased. It is understood, of course, that the attending physicians will have continuous service.

At present certainly a sufficient number of physicians can be obtained to act as Chiefs of the various clinics, who are trained, not only in methods of physical diagnosis, but in the other more fundamental methods of clinical study as well, and who are able to act as directors of such clinical laboratories as well as have supervision of the nursing and immediate care of the patients. If such men cannot be obtained, there is something radically wrong with medical training in the past. Twenty years ago such men were not available in this country, but if the Hospital will provide opportunities such as mentioned there will be little difficulty in obtaining a proper Chief for each of the medical clinics. Without such provision, however, it is hardly

likely that it will be possible to obtain the services of the kind of men needed, and the Hospital will gain very little from the change of plan. If the proposed Chief of clinic is simply going to devote a few more hours a day than is now given to physical diagnosis, very little will have been gained by the proposed change, except the endowment of a series of men with $5,000 a year each.

As to the proportional part of salaries which the Hospital and medical schools should pay, it seems that the provisions of the plan are equitable and just. If the Hospital is willing to accept the recommendation of the medical schools regarding appointments in the clinics in which teaching is done, the schools should consider themselves fortunate that the Hospital is willing to pay half.

At the present time it may be impossible to give the so-called Advisory Committee powers other than advisory. When the ideal medical staff is obtained, however, I feel that in the ideal hospital this board will have large powers as regards all the details of hospital management. This may not be, however, until instead of half time chiefs of clinics there will be full time chiefs.

Dr. F. A. Washburn, Administrator
Massachusetts General Hospital
Boston

I enclose a reprint which gives my views on the subjects in question better than I can do it in a letter.

In your paragraph 2, under the duties of the Superintendent I should add the control of the training school for nurses. I should, however, have an advisory board of ladies and gentlemen interested in nursing so that the general policy of the school may be broad and not narrowed by the individual views of a given superintendent.

Under paragraph 3 I should go a step further and do, as we have done in this Hospital, delegate to this board authoritative control of the medical and surgical affairs of the Hospital, but when it comes to the question of administration or the spending of money I should make that function advisory only.

I should make this "Advisory Committee," as you call it, the nominating body for all staff appointments.

I am sending you a copy of our rules and regulations. Our Executive Committee corresponds to your "Advisory Committee." It is essential that the superintendent should be the secretary of this committee.

I think that the paid Chief should be nominated and appointed by the Hospital and not by the medical school. Nomination, however, should be made after consultation with the medical school and, if possible, an agreement with them. The functions of a large general hospital are to-day too complex and too important to the community for us to allow the single function of medical education to be the only one considered. A man may be an excellent professor of medicine and not have any adequate conception of the duty of the hospital to prevent and cure industrial and social disease. He may not be willing to use the social service as it can be used to the great advantage of a hospital. In other words, the hospital must see to it that the chiefs of service are broad men and capable of looking out for all the functions of the hospital. The medical school has only one thing in mind, that is, teaching. If a man combines the qualifications which the hospital needs and the qualities which the school needs, so much the better. If he has not the qualities which the hospital needs I would put him under the chief of service, but let the executive committee see to it that he has the necessary teaching material. It is not essential that the professor of the medical school should be chief of hospital service. The teaching material can be given him without his holding that position.

I believe it is wise to pay a Chief and to have the Hospital pay its share.

Dr. George Dock
St. Louis

I shall discuss the Tentative Outline by numbers.

1. Very good.
2. Very good.
3. Very good.
4. Very good.
5. I think a paid service is the only way in which to get the work necessary in medicine at the present time, and the payment should be in proportion to the quality

of service rendered and the time devoted to the work. As the head should have the chief responsibility and should be doing actual work teaching undergraduates, training the staff, guiding investigations, and himself investigating, enough should be paid to make it possible to secure the services of a thoroughly satisfactory man. The salary suggested, $5,000 a year, suggests that the head must add to his income by some other activity, such as private practice. This will, probably, always be possible. On the other hand, unless the medical school would materially increase its share of the income, the Hospital might lose the services of men who would not care to practice. Four hours a day, for example, is not enough for the activity I have mentioned, although I should say it is enough for the suggested salary of $5,000. An age for retirement is proper, but should not be based, in the case of medicine, on the same grounds that apply in the navy and army, and perhaps in surgery.

The attending physicians and surgeons, I assume, are not to be paid. If this is so, the conditions under which they hold their service should be very carefully arranged; such free services may be very valuable, but justice to both the attendants and the hospital must be assured. The rest of the details in number 5 are good.

6. Good, provided incumbents have proper experience and qualifications.

7. Good, provided personal element is considered in addition to the result of a technical or professional examination.

8. Power to discontinue service should be based on cause, with the right of investigation if desired by the individual concerned.

9. The scheme proposed should be very satisfactory, but would have to be carefully worked out. It would be essential that all heads of clinical departments be able to keep in close touch with the Pathological Department and that the methods followed by the Pathological Department be satisfactory to the clinical Chiefs.

In answer to number 2 of your letter, I do not think the plan provides a large enough staff of paid men. There should be some men beyond the rank and experience of internes and subordinate to the residents. There should also be full time men of experience doing special clinical work in bacteriological, chemical, and physiological sides. Such men should have positions of about the rank of resident and the salary should be commensurate with their value; say, from $1,500 to $3,000 a year.

3. Both the City and the colleges would seem to be getting a great deal for their money if we believe the heads are to devote themselves chiefly to their work and not use the positions for aid in private practice. As, however, the positions are in the public service, which would appeal to some men, the salaries may not be too small. I am not sure whether they are as large as those paid in other municipal departments of the same importance.

4. I find no serious objections to the plan, but think it would be a good one, and that some of the details, such as size of staff and the salaries for all ranks, would have to be based on the possibility of getting the best men for the places.

Dr. Alfred Stengel

Philadelphia

In answer to your letter of December 15th regarding the proposed plan for government and administrative organization of Bellevue Hospital, I subdivide my remarks a little differently from the order of your questions.

1. The general plan seems to me well adapted to secure for Bellevue Hospital the kind of services that modern conditions demand. The casual and irregular attendance of physicians and surgeons so customary in American hospitals up to the present day should be done away with, and the principal features of your plan—viz., to have continuous service and to exact half day work—should be introduced everywhere. It is obvious that such exactions will restrict the occupancy of hospital positions to a certain type of men—those who are interested in more than merely perfunctory care of patients and whose private work is limited to consultation practice. When such an arrangement is effected our hospitals will be in practically the same position as those of Europe, especially the Continental ones. The headship of a hospital service under these circumstances carries with it a special sort of dignity and establishes the incumbent as a consulting physician or surgeon of high rank. In short, it establishes a special class separate from family practitioners, and by reason of its exactions would reserve such positions for men whose interests are centered about teaching, investigation, and whatever pertains to advance in medical science. It seems too obvious to require much discussion that the facilities of well equipped hospitals should not be

at the disposal of those who give many hours daily and their best efforts to general practice and only perfunctory service to the hospital with which they may be associated.

2. The question of voluntary versus paid service cannot be answered without reference to local conditions and present day customs. If the European system were now in vogue and if the holding of hospital chiefships gave men here the distinction among the laity as well as the medical profession customary in Europe, little discussion of the matter of salary would be necessary. A half day free for consultation work would be ample for individuals in this fortunate situation to earn enough to be satisfactory to the desirable type of men. Unfortunately, up to the present time, such hospital positions even in the best hospitals of New York and other large cities have been mere incidents in a general family practitioner's daily work. Should one hospital like Bellevue change the system and make special exactions upon its Chiefs while other hospitals continued in the old way a great hardship would be imposed upon the newly made Chiefs thus restricted. Later, doubtless, as other hospitals adopted the same plan the difficulty would grow less. Under the circumstances, it seems to me that the introduction of the new system ought to carry with it a provision of salaries to those who will be asked to give up so much of their time. Whether these salaries shall be provided by the hospitals or by the medical schools or both is a matter partly to be decided by the kind of hospital involved. In the beginning, undoubtedly, the interests of both the Hospital and the medical school will be best served by a combination. Later, it seems to me, the Hospital should be absolved from any payment of salary. In giving facilities for study and a position of distinction, plus the opportunity which should be free and ample, to teach students, the Hospital will pay its share. In paying a salary sufficient to hold the best type of men to this kind of work in return for their teaching of students, the medical school would be paying its share. The final ideal, then, would seem to me to be the requirement as to time of service which you specify, the granting of abundant facilities, and the right to teach on the part of the Hospital, and of an adequate though moderate recompense in return for a reasonable amount of teaching on the part of the medical school. The immediate introduction of this plan *in toto* would, I fear, deprive the Hospital of some of the most desirable men who would be compelled to seek elsewhere for opportunity upon easier terms. A salary, such as you contemplate—made up by equal sums from the Hospital and medical school—would avoid this difficulty, while at the same time it would prevent political maneuvering for the positions, which would be almost certain to happen if the Hospital paid the salaries wholly.

3. It seems to me your Committee has decided upon the best plan for securing the kind of service modern requirements demand. The alternative, or requiring full time service, would involve the selection of an entirely different type of men. A half day's work is as much as most men's strength will permit them to give to steady hospital service. The rest of the day would either be wasted or devoted to study and investigation probably in laboratories. The former contingency would be unfortunate; the latter would be satisfactory in the case of a few men, but would be undesirable if required of all. The better plan, therefore, to secure good clinical men—medical or surgical—seems to me the one you have adopted of requiring a half day's work and leaving the chief free to do consultation practice during the rest of the day.

Dr. David L. Edsall

Boston

1. I do believe that a paid service is preferable to a voluntary service because I believe that hospitals, if well run, must have more time from their staffs, particularly certain members of their staffs, than is possible for men to give if they get no remuneration for it.

2. I think the plan you submit provides a satisfactory means of securing a paid service. The only comment upon this point that I would make would be that you say the City should pay one-half the salary, but such half shall not exceed $2,500 per year. It might be impossible to get enough of a man's time for $5,000 a year and it would seem to me to be better to say that the City pay part of the salary but that that part shall not exceed $2,500, if it be necessary to limit the City's share to that amount.

3. I have indicated an answer to this in the last question. I think, however, it is fairer that the medical school and the hospital should equally share in the salaries paid, and it is best for the relations of the individuals to both the medical school and the hospital that they should feel an equal responsibility toward both and should

not, as has been too much the case in the past, feel that their serious responsibilities are chiefly with the medical school and that the hospital has to take the leavings if they get pushed. I think that the relations all around would be better if the men all felt both directly and indirectly they were equally responsible to the hospital and the school and financially as well as otherwise equally in the control of each institution. If in any way heretofore the service to hospitals has not been as good as it should have been, I think it is perfectly fair to say that that is because it has been impossible for a large proportion of medical men to give any better service, and the hospital has not provided them with the opportunity for giving better service. On the other hand, if the hospital does provide them better facilities and pay them, I think they can hold them clearly responsible for whatever duties are assigned to them.

I think the plan that you send is, in its general features, an excellent one. It is not dissimilar to the one now in use in the Massachusetts General Hospital, and which seems to be working very well here. The only point that I would seriously criticise being that I think the proposed advisory medical board ought to have rather more than simply advisory powers. That is, I would not consider giving them power in any way over the finances of the Hospital or over purely administrative problems, nor would I give them final power regarding anything excepting certain internal matters which can quite properly be determined by such advisory board, but I do think if you get a group of first rate men together you cannot long keep them interested and active or very devoted to work that limits them absolutely to purely advisory things, especially if they grew to feel that their advice was very frequently not being followed.

I think it very desirable that all nominations for staff positions should come through the proposed advisory board, and through no other source, unless, in individual cases, it became impossible for the Trustees and such advisory board to agree, in which case the Trustees would of course have to exercise final power. I think a great many administrative details which relate really to the work of the chiefs of service and their assistants ought to be determined by an advisory board rather than by the purely administrative officers. That we find perfectly feasible, and indeed far more effectual, at Massachusetts General Hospital than the other method of running things.

Dr. Richard C. Cabot
Boston

In answer to your questions, I would say:—

1. I consider paid service preferable to voluntary service, because a hospital can control and criticise the work of its paid employees far more satisfactorily and because the plan seems to have worked well in other hospitals.
2. I think your plan of starting with paid Chiefs of Service is the best one, as an entering wedge. Ultimately I think all physicians connected with hospitals will have to be paid, but not at present.
3. I think the proportion of salaries, as divided between the Hospital and the City, is fair.

I know nothing, of course, about the special provision for the "Fourth Division" but I see no objection to the plan, as outlined, so far as I understand it. In essentials, it is the plan under which we are now operating at Massachusetts General Hospital, though we have not as yet voted to pay our Chiefs of Service.

Dr. George W. Crile
Cleveland

I have read with much interest your communication of December 15th, regarding the proposed plan for the organization of the Bellevue Hospital.

On the whole, the scheme as outlined should prove workable and advantageous. I would only suggest that to my mind the various Services should be organized on a strictly military system, so that a single individual in each Service has the undivided responsibility for that Service and controls a series of residents of different grades of rank, who receive varying remuneration. These assistants or residents should be promoted by seniority or fitness, or should be discharged on the recommendation of the Chief of the Service.

DR. WINFORD SMITH
The Johns Hopkins Hospital
Baltimore

1. I consider a paid service preferable to a voluntary service. It enables the physician to spare more of his time and it enables the hospital to demand more of his time.

2. I believe the plan does provide an acceptable means of procuring a paid service.

3. I think the proportions of salaries as arranged are probably a fair adjustment, inasmuch as it is customary for the medical colleges to pay some salary to their professors, and presumably the Chiefs of these clinics will be the professors of the medical schools. Strictly speaking, of course, the City should pay the entire salary for the service rendered to its patients, if we are to accept the system of a paid service, and I believe we shall have to accept it as desirable.

4. Of course the first objection that will be made is that men with large reputations cannot afford to give half of their time to the Hospital for the small salary provided. The answer to that is obvious. It is doubtful whether or not a hospital can afford to place its patients in the hands of a man who can give so little of his time to a hospital. It is my personal opinion that there are earnest, ambitious, and scientific men, possibly at the present time of a lesser reputation and possibly of a younger generation, but men who would be eminently satisfactory from a professional point of view, who could be easily found for such service. Furthermore, I feel very strongly that such a man, giving sufficient time to the work to be thoroughly in touch with his cases and to have full knowledge of all that is going on in his service, even though he be of lesser reputation, is a much more valuable man to a hospital than a man of large reputation who gives so little time to the service as to have only a most superficial knowledge of the cases under his charge.

5. In paragraph 5 of the plan outlined, I think it undesirable to assume at the start that men of the caliber it is hoped will be provided by this system are not going to perform their duties in good faith, which assumption is apparently manifested by the attempt to limit these professional men strictly to certain hours. Professional men resent this. I think the statement that they are to give one-half their time to the Hospital is sufficient; but to say one-half of each day and to make it necessary for them to put in four consecutive hours is unnecessary and objectionable.

Nominations should be made by the Chiefs to the Medical Board or the Advisory Committee, whatever it is called, and by the Committee to the Board of Trustees. The Trustees should not act on any nomination unless approved by the Medical Board. I think it would be wrong for the heads of the Fourth Division to be nominated by the Council of the Academy of Medicine. I cannot see that the Academy of Medicine has anything to do with the matter, and not even the New York Academy of Medicine can guarantee that its members will not play medical politics with reference to such appointments; and medical politics as related to public institutions can be just as bad as any other kind of politics.

6. The resident physicians and surgeons should be paid entirely by the City. They are hospital appointments, strictly speaking, not university appointments.

DR. THEODORE C. JANEWAY
New York

The placing of hospital services under single and responsible heads, medical and surgical, has been so long in operation in all foreign countries and with such entire success both from the standpoint of hospital administration and of university instruction in medicine, that there should be little need of argument for its adoption here. The main obstacle has always been that the time required of such heads for effective supervision is so great as to be impracticable under our system of voluntary service of physicians and surgeons. Men serving without pay can naturally give a much smaller portion of their time, and it has been convenient for them to give this for only a portion of the year. Hence our rotating services. With the introduction of a paid service, such as exists in Germany, the single headed organization becomes at once practicable, and for this reason I am a thorough believer in it. In addition, the receipt of the salary from the City makes for strict accountability for the performance of their duties by the salaried appointees. I believe that your plan—under the peculiar conditions existing in Bellevue Hospital of Divisions, three of them already affiliated with medical schools—provides a thoroughly acceptable means of securing a salaried

staff of the highest order of professional ability. Your division of the expense between the City and the medical colleges seems to me just to both parties, and to represent as nearly as can be estimated the amount of time which the physicians and surgeons will give respectively to the conduct of their services and to teaching. I can find no serious objections to the plan as outlined.

Under existing conditions it would be possible to debate profitably the disadvantages of the present arrangement of Divisions, particularly as it affects coöperation with the Pathological Department, but I believe that no proposal to change the existing Divisions could meet with acceptance at present. Therefore, I feel that, without making any changes in the framework of the Hospital organization, you have provided a scheme which both for the Medical and Surgical Services and for the Pathological Department should result in much more effective service to the City and much more thorough utilization of the vast facilities of Bellevue Hospital for medical instruction and investigation.

DR. GEORGE BLUMER
Dean of the Medical Faculty
Yale University
New Haven

I am in receipt of your letter of December 15th and am answering it to the best of my ability. In judging of the value of answers on the main question you raise—namely, paid vs. voluntary service—I think that you should take into account the fact that paid general hospital service has been tried in the United States in very few places and that consequently any opinion on the subject must be either based upon rather limited observation or else must be purely academic. My personal experience with paid services in a general hospital is limited to what I observed when a house officer in the Johns Hopkins Hospital some twenty years ago.

1. I do consider a paid service preferable to a voluntary service. From what I have seen of voluntary services in a number of American cities, a considerable proportion of them are inadequately attended to. This sometimes results from the fact that the attending physician feels that he must never neglect his outside practice, which is his only source of income; and it sometimes results from lack of conscience on the part of the attending physician or surgeon. It seems pretty obvious to me that the main advantage of a paid service is that the employer can hold the employee strictly responsible for a stipulated amount of his time and any neglect on the part of the employee can be very promptly checked.

2. In a general way the plan that you propose seems to me a fair and equitable one, although there are some things that I should have a little doubt about, possibly because I do not understand the reasons for them. Such, for example, as the appointment of a superintendent for a prescribed period of years.

3. I consider the proportions of the salaries to be paid by the medical schools and the Hospital as entirely fair. This is the proportion that is paid in the Brigham Hospital in Boston, and, I think, from my experience in teaching work in hospitals, represents fairly the proportion of work given to teaching as compared with the proportion given to the actual care of patients. Of course, the two processes are so intimately associated that they cannot be sharply separated.

4. The only objection that I find to the plan is the amount of salary, and when I say I object to this I do so only in a modified way. I think that the salary is sufficient for the amount of time demanded; i. e., half a day. The only question in my mind is whether by doubling the salary and getting the medical schools also to double it, and insisting that the appointee devote his whole time to hospital work and hospital research, you would not get better results. You probably know that this is the plan that the Rockefeller Foundation is trying to inaugurate in Baltimore. It is fair to say that it is purely an experimental plan. It has not been tried out anywhere, but the logic on which it is based is, to my mind, so unassailable that it seems to me the plan ought to be thoroughly tried out. It is, of course, highly improbable that you could get the present Chiefs of the three medical school Divisions to accede to such a plan, as they are doubtless making much larger incomes than ten thousand dollars a year. The medical schools, however, might be willing to accede to the plan and substitute younger men with different ideals for the present Chiefs. I offer this suggestion to you for consideration. It may be, in the opinion of your Committee, entirely impractical, owing to local circumstances. On the other hand, it might appeal to your Committee as an opportunity to place Bellevue Hospital—which has always

been one of the great hospitals of the United States—in the position of one of the leaders in the reform of our hospital system.

I am in receipt of your letter of December the 19th.

I thoroughly agree with Dr. Delafield's view that as a rule only the advanced stages of disease are seen in hospitals. I would point out, however, that this is not true of the out-patient department and that there are opportunities in the out-patient department to meet with and observe the early stages of disease. I am quite of the opinion that the whole question of full time clinicians in hospitals is still an open one. I merely feel that theoretically the arguments are so strongly in favor of the desirability of full time clinicians, provided, of course, that they have gone through a training that has acquainted them with the early stages of disease, that I believe the plan should be very carefully tried out. I am satisfied that the plan you suggest putting into effect will be a great improvement over the former one.

Dr. Henry A. Christian
Peter Bent Brigham Hospital
Boston

(1) I consider a paid service in a hospital preferable to a voluntary service, for the reason that it places the hospital in the position of obtaining a more adequate service from its attending staff. A continuous service appears to me to be very essential in the modern hospital, and it seems unreasonable to ask the large amount of time required in continuous service unless the service is remunerated by salary. In paying salary for the service, it seems to me that the hospital is in far better position to hold its attending staff up to certain requirements as to visits and character of the work. With close attention to the work and a continuous service, it seems inevitable to me that the service will become a productive one along the lines of research, and that the patients will receive better care and more thorough study, leading to better diagnosis.

(2) It seems to me that the plan suggested by you provides an acceptable means of securing a paid service.

(3) I regard the arrangement of the proportion of salaries between the colleges and the City as satisfactory, and believe that this new arrangement will both increase the efficiency of the Hospital work and materially improve medical instruction.

(4) I have no particular objections to offer to the plan as set forth, but I think that in some respects it is not definite enough. This is particularly in relation to the Superintendent of the Hospital. In my judgment, the usual autocratic position of the superintendent is one that does not make for the best work in the hospital. I would seriously question the advisability of clause 2, which places the control of admissions, distribution, discharges, and social service entirely under the charge of the Superintendent. I believe that the Superintendent should be the executive in regard to these matters, but that he should be the executive under rules and regulations drawn up by the Advisory Committee provided in clause 3, which rules should not become effective until approved by the Board of Trustees. I believe that the Advisory Committee provided under clause 3 should have more of a function than is suggested in your arrangements. I think it should be provided that all matters concerning the policy of the institution and the administration of the various departments, executive and professional, should be submitted to this Advisory Committee prior to being presented to the Board of Trustees, and the Board of Trustees should not take action upon such matters until they have had a report from the Advisory Committee. Furthermore, it should be provided that the Advisory Committee in case there is a considerable difference of opinion should have access by means of a representative to the Board of Trustees to present respectively the majority and minority sides of the question. Furthermore, I believe that provision should be made so that the Medical Service and the Surgical Service and the Pathological Service should always have as free access to the Board of Trustees as does the Superintendent. In other words, the present custom of having the Superintendent act as spokesman to the Board of Trustees, which is a method generally in vogue, is undesirable. All of these suggestions tend toward making the Superintendent the administrator of the Hospital, and to give him definite duties in this regard, and to make his position coördinate with the various Chiefs of Staff. There is absolutely no reason why the Staff should in any sense of the word be subordinate to the Superintendent, and that custom generally in vogue in our hospitals is to my mind totally indefensible, when a continuous paid service exists.

In regard to clause 8, I think there should be inserted a provision so that these various men could not be discontinued by the Trustees except for cause and after a hearing.

Your plan does not make any provision, it seems to me, for the organization and management of the very large number of special laboratories required in the modern hospital apart from the pathological laboratory. For instance, a medical service needs various forms of laboratories for investigation of patients, and these should be directly under the control of the medical service. The arrangement with a pathologist as director of the laboratories in control of all of this work does not seem to me to have been a success in most of our American hospitals. The laboratory is just as much a part of the medical work as the wards, and should be so regarded. The chief of the medical service cannot adequately handle his patients unless he can direct the laboratory work. This does not refer to the question of performance of autopsies, pathological examination of organs and tissues, and a number of the forms of serum diagnosis and bacteriological study which should be done equally well under the direction of the pathologist, and probably better, but it refers to such matters as various chemical examinations, electrocardiography, studies of respired air, etc., and the more ordinary routine laboratory examinations of blood, urine, and feces.

Notwithstanding these criticisms which I have made, I believe the plan is a splendid one, and represents a very distinct advance in the organization of Bellevue Hospital, an advance which should be imitated in many other hospitals in this country.

Dr. Simon Flexner
Director of the Laboratories
The Rockefeller Institute for Medical Research
New York

I am unable to answer all your questions, since regarding many of the points raised I am not in a position to advise. I am, however, persuaded that a continuous paid professional service would provide a far better service to the Hospital than the present arrangement.

Dr. Graham Lusk
Department of Physiology
Cornell University Medical College
New York

In 1909 I wrote the following:

"A scheme for the redemption of New York from reproach is this: Raise a fund of $500,000. Pay the professor of medicine half the income, or $10,000 a year, in return for which he shall spend half his day from 9 in the morning to 1 o'clock instructing students, making rounds in the hospital, and supervising research work. He should have under him two assistants at $2,500 per annum, who should be permanent resident internes of the hospital and men who can grow to be professors of medicine. The $5,000 income remaining should be used for the expenses of research at the discretion of the professor."

This plan was intended for a hospital under New York conditions. The salaries were placed high in order to attract men in medicine of the quality of Herter, Edsall, Janeway, or Howland. It was believed that the adoption of such a plan would give to any school or hospital the leadership of the country in medicine. It seems wise that the hospital should share in the cost of an establishment which would so enhance its reputation and the welfare of its patients.

Salaries of five thousand dollars for the service of chief physician and surgeon are sufficient to make a workable scheme with which to start, but are insufficient to render the positions the great medical and surgical prizes of the country, as they should ultimately become in such a hospital as Bellevue and such a city as New York. If one or more of the colleges be wise enough to grasp the opportunity they can, at any rate, provide whatever additional salary be necessary to obtain men whose leadership would mean medical supremacy in the United States.

Leadership can never be obtained through the old fashioned types of "good, practical men." Such there are to-day aplenty. It must be obtained through men tutored

in the modern scientific school. In the latter class there are a few good young men; only a few, unfortunately, for the upbringing of the vast majority of medical students has been in an atmosphere in which emphasis has been more upon the commercial than upon the intellectual or scientific side of medicine. The average clinician is guided by his impressions. Scientific facts do not often enter seriously into his mind.

It is beyond all doubt desirable to change the medical atmosphere and to cultivate the intellectual and scientific appreciation of the diseased organism. This should be possible in a great hospital.

In any plan to promote the welfare of the hospital it is necessary that the physician should profit by the criticism offered by the pathologist. The pathologist also should be responsible for the routine examinations in the wards.

But it is essential that the medical and surgical heads of divisions be in a position to control investigations into the cause and cure of disease. Otherwise there would be no satisfactory scientific life; no work which would make the wards the glory of a master mind in charge.

It is well to look the situation squarely in the face and seek the best that the world offers. It is of primary necessity to put aside the inherited defects of an antiquated system which hinders the proper development of medical knowledge.

Dr. John Howland
The Johns Hopkins Hospital
Baltimore

I have not been well for several weeks and thus have been prevented from answering your communication in regard to the proposed plans for Bellevue and Allied Hospitals. I understand that matters have changed considerably and that answers to your questions of December 15th would not be pertinent now. I should only like to say that I am in favor of compelling the medical schools to assume their proper responsibility in the conduct of the medical services of the hospital and that I am distinctly in favor of a paid staff.

Dr. T. W. Hastings
New York

In Section V, the natural inference would be, that the Chief of the Medical and the Chief of the Surgical Services, for the medical school, would be the professors of medicine and surgery. A man of more than ordinary ability and of high attainment could not be asked to accept such a salary as suggested. It would be absurd even if the medical school increased it threefold; since the same Section V states that such a chief must serve not less than half of each day, or not less than four consecutive hours.

From past experience at Bellevue one knows that the time required for thoroughly covering three medical wards is variable. With several "new admissions," or even a few patients desperately ill, one ward might require two hours attention, while the other two wards, if running "light," might not require more than 15 or 20 minutes each. For one interested in the work, however, the freedom from practice which such a position would guarantee, would permit considerable time to be given to hospital service, in work connected with the medical wards, such as laboratory investigation, and post mortem examinations at the morgues.

It seems to me that the four consecutive hours might be defined in advance, or it should be understood that considerable latitude in the kind of service should be granted. It is certain that the places will be best filled by some of the younger, well-trained medical men.

In Section IX, the demand that the medical colleges should be responsible for an assistant in pathology is excellent, since the work of the Pathological Department is excessive and calls for a large staff, and is essentially necessary for proper instruction of medical students. There is every reason in the world why medical schools should share in the expense of conducting a pathological division. To this Section IX, however, should be added that the Director of the pathological laboratory should have supervision of the morgue, located in the new pathological building, and that the morgue records be accessible to the Director at any time, for the use of the attending staff, particularly in relation to patients who have died from unknown causes and have been classified as Coroner's cases. It should also be insisted upon, if possible, that the new morgue be utilized at an early date.

Dr. W. G. MacCallum
Columbia University
Department of Pathology
College of Physicians and Surgeons
New York

Of course the primary object being the proper care of the sick, it is obvious to all who have had experience of both plans that this is best attained by the most intimate possible relations with the university medical school, not only because the best available men are there, but because with their facilities for the care of the sick, and with the incentive furnished by teaching from the patients, those patients are more intelligently and assiduously treated. I therefore find it deplorable that the Fourth Division should continue to exist without connection with any medical school. I cannot see that there can be any reason for it except the gratification of a few men who wish to use the Hospital for their private good, and I am told that even in that Division such men as Dr. Alexander Lambert feel the necessity for teaching and actually use their services in this way in connection with some college.

I cannot see, however, that any high degree of efficiency is ever to be attained as long as there are three colleges jealously struggling with one another in the Hospital for selfish reasons. If these colleges could be amalgamated into one and that one given charge of the Hospital, every difficulty of organization would fall away at once. But if this is impossible, it seems that the same end might be reached by giving over the whole Hospital to one of the colleges, preferably one of those immediately adjacent to it, since the college which had control of such a splendid material would soon overtop the others and constitute itself the one desirable center of medical education in New York.

The main point in all this is that there should be a single headed organization, eliminating conflicting factors. Of course it might be possible to establish three separate and independent university hospitals in Bellevue, but I think that would entail an extravagant duplication of facilities and apparatus, as well as untold complexities of organization. Possibly the suggestion, which I believe has already been made, will go far toward this aim. I refer to the plan of separating Medical, Surgical, Obstetric, Pediatric Services, etc., and putting each under the control of one man who shall hold office throughout the year, this man to be the best that can be supplied by any of the three schools. In that case the Obstetrical Service would be controlled by the appointee of one school, the Medical Service by that of another. Each department could then be organized with the same perfection as a part of an ideal university hospital.

But in this case it is essential, I think, that the college should be given the power to actually appoint this head of a department, and that whatever men he appointed as his assistants should, as in the case of the university assistants, be nominated to the administration committee of the medical school, passed on by the faculty and trustees of that school, and ratified by the Trustees of the Hospital. In this connection there should be at least one member common to the Trustees of the Hospital and medical school.

With regard to the salaries of these men, I think the apportionment between the City and the college fair enough from a financial point of view, but with the above method of control in mind, I wish to especially emphasize the fact that it should be the college that directly pays the salary to each of its appointees, the City paying its half into the treasury of the college for this purpose. In this way the head of the department is directly responsible to one institution, which pays him his salary. He cannot serve two masters, and if his instructions and criticisms as well as half his salary are to come from two different sources, demoralization is sure to ensue. The criticisms and instructions from the City as to the conduct of the department should be addressed to the college, which should then impress them upon its appointee, the head of the department, for further transmission to his staff.

Of course I think a paid service preferable to a voluntary service, because it introduces a greater sense of obligation and responsibility, but more particularly because it is only the very exceptional wealthy enthusiast who can devote all his energies to hospital work, as he should, without an adequate salary to keep him alive. There is no other man who can support himself and give an amount of attention to hospital work which would justify his being appointed as head of a department in Bellevue, and the acceptance of a hospital appointment for the mere prestige and its benefits to the appointees' private practice is inevitably deleterious to the hospital.

The other questions are answered, I think, in what I have said. These remarks apply precisely to the pathological laboratory also—it seems doubtful that without any voice in appointments and management of the laboratory work of the Hospital, each college department of pathology should send a man to carry on its routine. On account of the admirable personality of the present Director of the Laboratory, Dr. Norris, I should undoubtedly be glad to do exactly what you suggest now, but in principle I think that plan is not acceptable.

Dr. George Emerson Brewer
New York

1st. I do not consider a paid service preferable to a voluntary service, for the reason that a hospital which offers the advantages and facilities of the new Bellevue, will attract the very best talent in the community without pay of any kind; provided you will make the service an attractive one, and one from which they can reap a fair amount of personal benefit in the way of experience, gathering statistics, publishing reports, and teaching.

In other words, give one man on each Medical and Surgical Division a continuous service, making him physician- or surgeon-in-chief; next give him plenty of assistants, so that the minor details in the actual care of the patients shall not be too onerous for the Chief. This will enable him to give his attenton to the great problems, to personally assume the care of the graver cases, and in addition will give him enough time to devote to the organization and general management of his Division, and to secure the best results through efficient service and team work on the part of his subordinates. Offer such a service to the very best men in the community, and you will see that they will gladly accept and will serve loyally without pay, and, if necessary, give up any other hospital appointment which they may hold.

2nd. The plan you outline will provide an acceptable service, but I do not think you will get the very best men at the head of each department, for I do not imagine that any man who would add greatly to the reputation of your institution would be willing to accept a salary, or be bound by the rules you have formulated.

3rd. I will not answer this question, for I do not approve of paying salaries to the visiting staff. I consider it a useless expenditure of money. I do favor, however, paid residents. The best plan to my mind would be to have a resident and an assistant resident on each Division. I think you could obtain the services of a well equipped resident for $500, provided the head of each service was chosen from the most distinguished men in the community. Most young men would prefer to serve without compensation under a distinguished surgeon, than to accept a position even with a large salary under a person whose name does not carry much weight in the medical community, and who perhaps would not keep the standard of his service at the highest point. It may be necessary on large services to appoint an assistant resident, and you could easily get one for $250 provided he might eventually be promoted to the position of resident. The rest of the ward work could be done by internes, preferably by advanced students, who could live in the Hospital, and devote a year or more to the service.

I may say, in passing, that at the present time the medical colleges in this community are considering the plan of requiring a fifth year in the study of medicine, and that fifth year to be devoted entirely to hospital service, the student during this period to live in the hospital and do the work of the house staff. If this becomes a State law, as it has already in several States, we will have to reorganize our methods of interne service, and it seems to me this is the best solution.

Dr. Robert J. Wilson
Superintendent of Hospitals
Department of Health
of the City of New York
Division of Hospitals
New York

1. No.
2. No. It is proposed to make the medical colleges equal partners with the City in the payment of the salaries of the medical attendants of the institution but allows

them no option either in the administration of it or the policy of retaining their representatives.

3. No. For the reasons given in answer No. 2.

4. My objections to the plans as outlined are twofold. First, I believe that the colleges will supply free of charge the best medical and surgical talent that they have at their command, and that they will see to it that their representatives give as much time as is demanded by the proposed pay scheme. As you know, these positions of attending physicians are coveted by the best men in the medical faculties (not necessarily those having the largest practices) and the opportunities offered by the position mean far more to them than the monetary consideration proposed to be given to their successors.

I am of the opinion, also, that every medical man recommended by the university is looked upon by it as a direct advertising asset. The success or failure that attends his efforts in the hospital service reflects directly to the credit or discredit of the university from which he comes, and no university can afford either from a scientific or economic standpoint to allow an unfit representative in any hospital with which it has connection. The salary proposed is not sufficiently seductive to draw surgeons or physicians who now enjoy the reputation for the highest skill, and is just high enough to be attractive to those of mediocre ability. I am inclined to think that the level of the institution will rise just to the height of the medical and surgical ability that administers it.

My other reason for being opposed to this plan is that, it seems to me, it will limit the usefulness of the institution for teaching purposes. If the Hospital were owned by a single medical school, or if it were the property of a private corporation, the scheme might work. For all of the medical attendants would of necessity be compelled to get their appointments from the governing body of the university and equally of necessity follow out the line of work as detailed to them; if they failed in this respect the governing body would remove them, and if they succeeded the governing body would commend them; but in this proposed scheme the university has not the power of removal, and although the representative of their own selection may fail to meet the requirements of the college, he will still be retained in his position, drawing money that they have to pay irrespective of their wishes. This is manifestly unjust.

The first four years of my administration of the Health Department's Hospitals was marked by a paid medical attending staff; for the last three years we have had a volunteer medical board, appointed by the Board of Health, which has had full and complete charge of the medical service, and, so far as I can see, the results obtained are equal to, if not better than, those obtained when we had the paid staff, and should we attempt to pay for ability of the character that we now receive, our budget allowances for professional services would have to be far greater than they now are.

I think the scheme as proposed, for a private institution where there is no conflict of authority in the board of control would be excellent, but it seems to me that in an institution where it is proposed to give over medical control with the responsibility of paying for it to one set of people and administrative control to another set of people, neither of which have any common interest, would be a mistake. After all, the only people to be actually considered here are the patients, and they should have the very best medical and surgical attention they can get. This is not obtained by limiting the supply to a few positions with mediocre salaries.

Dr. William H. Park
New York

I do not think that a paid service is preferable to a voluntary one at Bellevue Hospital. The reasons for this opinion are that the colleges either do or can be compelled to have the attendants give sufficient time to their services. It is very important for the colleges to use the Bellevue service to give good training to their men. This is especially true for the University and Cornell Medical Colleges. I know that it is perfectly possible to have capable men giving sufficient hours both for the patients and for the students. I think that the plan advised would also secure capable men. It would, however, in my opinion be an unnecessary expense to both the colleges and the City. If adopted, I do not think that it is the best policy to apply half of this expense to the colleges. In the middle west the people are more and more coming to consider that medical education is the duty of the state and should be supervised and supported by the people. The long and expensive education now required is solely for

the good of the people, and adds expense and no income to the universities. The medical schools are now a great financial drain on their universities and no school can now depend on fees for its expenses. Germany and France have also adopted the principle of the state largely supporting medical education. I think to add this drain to the medical schools will cripple the other activities. It is urgently required that some pay be given the physicians in the Out-Patient Department.

The opinions I have here expressed are my own opinions. I have talked these matters over with a number of prominent physicians and surgeons who are connected with hospitals and the great majority agree with me.

One objection made by many is requiring four hours of compulsory surgical service *each* day. This would interfere with a man carrying out private practice more than is wise and might prevent the obtaining of men of the first rank. An *average* of four hours service would allow the necessary time and be much more acceptable to suitable men. Each man should have permanent assistants who could be delegated to do the simpler operations and care for the less difficult cases. My objection so far as expense is concerned would hold for requiring the college to support a pathologist. In this case I think it would be fair to ask the college to pay half the fee. This sum would be small and the pathologist would take care of a necessary part of the college teaching which is now paid for. In other respects I think the report is acceptable.

DR. JOHN B. MURPHY

Chicago

2. I feel that the admission and distribution of patients should be entirely under the charge of a superintendent under a definite plan of outline; that the discharges should be made by the superintendent and on the suggestion or order of the attending physician.

3. All advisory boards that I have had anything to do with in hospital management for the past four years have been either purely ornamental or officially detrimental.

4. The out-patient department should be subdivided so as to work in with the subdivisions of the ward service.

5. The salaries that you suggest should not be sufficient to secure the class of men that you can have voluntarily free, nor should they give you as good a service. There is no man in Chicago of prominence in the profession who accepts a voluntary free service in a hospital that does not give it the best of his time and attention. I feel that the salary mentioned could not possibly secure such men and such service for the patients as they receive now gratuitously. In our County Hospital arrangement we have a very definite requirement as to attendance, etc.

6. A partnership with a medical school or with many medical schools would, in my opinion, be a very undesirable thing for the City of New York or for the Board of Charities.

7. The method of selecting internes, I think, is a good one and should be conducted by written examinations and on a secret plan.

8. I think the powers of the Trustees should be restricted, and that a man's service should not be discontinued without a hearing both before the staff and the Board of Trustees. Trustees and doctors are all human and they become entangled in their relationships, and a great injustice might be done to the patients as well as to the doctors if star chamber proceedings were permitted. Furthermore, every man of ability would very seriously question accepting a salary and taking a position, if he felt it might be discontinued without a just and adequate hearing and presentation of his case.

9. Pathological Department: The outline for this work appears to be a good one, except that I would insist that students be invited to attend the autopsies or that they be forced to attend them regularly. No autopsy should be made without the presence of from four to six students, as this is one of the greatest means of education at our command, and it is very much to be regretted that the large cities are permitting this incomparable opportunity for education to be overlooked at the present time. The salary for the pathologist seems too low. We would gladly pay double that amount for a pathologist at Mercy Hospital at the present time, and we are unable to find one. Unless the remuneration is increased, men will not devote themselves to that line of labor for a livelihood, as there is no livelihood in it.

Now, taking up the questions in your letter, I would answer them as follows:

1. I do not consider a paid service equivalent to a voluntary service, providing the voluntary service is properly arranged and the work properly classified and outlined.

2. The plan does not appear to me as providing an acceptable means of securing a paid service. It is trouble enough to get along with one college, let alone two or three.

3. The salaries are entirely inadequate to the service required.

4. I do not believe that you can secure as good service under your paid plan as you could without paying, providing each attending physician or surgeon is assigned a definite and continuous ward service for life, if his services are up to standard. He should have a competent associate or co-worker—associate, I believe, is the better name—and then he should also have one or two assistants. If these positions are made permanent life positions, with a continuous service, there is no man so big that he can afford to refuse them, and no small man can possibly fill them.

There should be definite hours of attendance, two or three a day, as the case may be, and the same hours or more should hold for the associate and assistants. Have the wards called, for instance, Dr. Jones' service or Dr. Brown's service. With the hospital service made up of a number of units of this class, there immediately begins a spirited competition as to which service will give the best results to the people; the best scientific training; make the best diagnoses; and make the best operations with the best final results. That will be a spirited rivalry that will stimulate a keen interest in all of the work of the departments. When a man feels that he is secure in his position, he renders competent service; when he feels that he is insecure, regardless of service rendered, then it is always a meager and stinted one.

In my association with the Cook County Hospital, which has been first as interne, second as attending man for 20 years, and third as consultant for thirteen years, my observations have been that the continuous service with individual responsibility for a ward or a division is what has made for the best results.

I have endeavored in this meager way to give you my impressions concerning the hospital work that has come under my observation. I trust it will be of assistance to you.

2. SOME PROBLEMS COMMON TO ALL THE DEPARTMENTS

THE PROBLEM OF ADMINISTERING THE MUNICIPAL HOSPITALS

New York City at present operates eighteen hospitals. Of these, four are operated by the Department of Bellevue and Allied Hospitals; four by the Department of Health; and ten by the Department of Public Charities. The question naturally arises, Why this division of authority? The division is due partly to a natural development and partly to an arbitrary separation: the Health Department having jurisdiction over contagious cases naturally developed hospitals for their care; Bellevue and its allied hospitals were arbitrarily and by a special act separated from the Department of Public Charities in 1902. This was done in the belief that better management of these hospitals would result.

The Health Department cares for contagious cases, including tuberculosis; Bellevue and its allied hospitals are supposed to treat only acute non-contagious cases, but do care for tuberculosis, pneumonia, typhoid, syphilis, and some other contagious and infectious diseases; the hospitals of the Department of Charities are of the same character as those of Bellevue Department, except that they treat more chronic and tuberculosis cases.

It is held, and rightly, that this division of authority is illogical; but some illogical arrangements do work. The situation needs analysis.

Each of the Departments administers its hospitals reasonably well, but there are, however, some shortcomings due to a conflict of authority.

When Bellevue and its allied hospitals were separated from the Department of Public Charities it was with the idea that the hospital problem of Manhattan and The Bronx would be handled by the Bellevue Department. It was intended that the hospitals on Blackwell's Island under the Department of Charities should continue to care for the chronic cases, and to these hospitals the Bellevue Department hospitals would transfer all long-term cases. The Brooklyn and Queens hospital problems were to remain under the jurisdiction of the Department of Public Charities. This division probably would have worked well had the Blackwell's Island hospitals remained solely chronic hospitals.

The attending staff and nursing schools at these hospitals from time to time brought pressure upon the Commissioner of Charities to give them an acute service, that they might thereby receive a more varied practice. As a result of this pressure Commissioner Drummond, in 1910, established at the foot of East 70th Street a Reception Hospital, which in character is an emergency station, operating an ambulance. The Board of Ambulance Service was induced to readjust the ambulance districts so as to assign a district to the Reception Hospital. The entire district formerly assigned to the Presbyterian Hospital and a portion of the Flower Hospital and the Harlem Hospital districts were combined to form the Reception Hospital district. The cases received at the Reception Hospital were transferred by boat to City and Metropolitan Hospitals. The change in character of the service of these two Blackwell's Island hospitals is somewhat indicated by the increase in the number of their surgical cases. Their records for wounds, trauma, amputations, fractures, sprains, burns, dislocations, cellulitis, abscesses, and concussions of brain, appear as follows:

	1909 Number of Cases	1911 Number of Cases
Metropolitan Hospital	402	634
City Hospital	546	706
	948	1340

Thus, the acute cases of Manhattan which were formerly assigned to Bellevue and its allied hospitals are now divided with the hospitals of the Department of Public Charities.

Whether it was and is necessary for the Island hospitals to develop an acute service in order to secure a good attending staff and to give a satisfactory training to nurses is an open question. A chronic service is not attractive to internes, but is appreciated by older practitioners; and while a good staff probably can be secured for a chronic service, the nursing problem is not so readily solved. Pupils get but a partial training from a chronic service and are little inclined to enter hospitals furnishing that service only.

On the other hand, the pure air, and freedom from noise and dirt make Blackwell's Island the choicest spot in New York City for hospitals caring for acute as well as chronic cases. If the hospitals on the Island are to be developed as acute hospitals they must have larger ambulance territory, which, in Manhattan, must be taken from private hospitals or from Bellevue and Harlem Hospitals. Here arises a conflict in interests between departments. Manhattan should have one hospital equipped to care for even the rarest injuries or diseases. Equipment and facilities of this character are expensive and cannot be duplicated economically, but such a hospital Bellevue is designed to be, and to this Hospital all rare cases requiring special treatment should be taken. With two departments each serving the same territory a proper distribution and classification of cases cannot be assured. It seems somewhat unwise and hazardous to design Bellevue for 2,000 patients and equip it with everything which can contribute to the proper treatment of injuries or diseases without being assured that it will have enough patients to occupy the beds so provided, or that the cases of injuries or diseases for which special appliances have been provided shall be received into it.

According to the division of authority now existing the Board of Ambulance Service can diminish the extent of Bellevue's ambulance district, or it can refuse or neglect to increase it when the enlarged Bellevue seems to demand it. The proportion of acute cases and the classification of such cases which should go to Bellevue or to the hospitals on the islands in the East River should not be left to a board independent of both Departments, and which may be more favorable to one Department than to the other.

The endeavor of the Island hospitals controlled by the Department of Public Charities to build up an acute service is not discreditable, nor, perhaps, would the endeavor be open to much criticism if the policy had been adopted openly and in consultation with Bellevue as representing the same territory. No attempt was made on the part of the Department of Public Charities when opening the Reception Hospital at East 70th Street

to reach an agreement with the Bellevue Department as to ambulance territory or as to classification of cases. It was an independent move, irrespective of the effect upon the Bellevue Department, and during the three years that it has been in operation there has been little or no coöperation between the Departments dealing with this phase of their work.

Previous to the establishment of this Reception Hospital the nurses serving in City Hospital were daily transferred to Gouverneur Hospital in the Bellevue Department, for training in the care of acute cases. By this coöperative program the nurses were given a very acceptable training in the care of both chronic and acute cases. After the establishment of the Reception Hospital this program of coöperation was abandoned and the nurses were no longer given an opportunity to serve in Gouverneur Hospital.

It has been difficult to secure pupil nurses in the hospitals on Blackwell's Island owing to the fact that they could not secure the experience in connection with acute cases which they desired and should have. The establishment of the Reception Hospital at East 70th Street has partially, but by no means wholly, overcome the difficulty. On the other hand, nurses serving in Bellevue Hospital have received training almost exclusively in the care of acute cases. This does not give them a rounded experience and they are sent out into private practice with comparatively little knowledge of the care of chronic cases. Again, none of the nurses trained in either Bellevue or the hospitals of the Department of Public Charities have experience with contagious diseases, since these are cared for, with but rare exceptions, in the hospitals of the Department of Health.

So long as the hospitals are more or less specialized in three separate and distinct departments the nurses will receive an unbalanced training, some receiving specialized training in acute service, others in chronic service, and still others in the care of the contagious cases. Nurses will not receive a rounded training, with experience in each of these classes of cases, until the three Departments reach some basis of understanding and coöperation which will enable nurses to be trained in the different classes of hospitals. An alternative to such classification or specialization of hospitals would be to provide these three classes of services in all hospitals; viz., acute, chronic, and contagious.

A difficulty, by no means minor, due to the division of authority over hospitals arises from the fact that the Bellevue Department has no powers of an Overseer of the Poor. These powers reside solely in the Commissioner of Charities. By Chapter 378, Laws of 1897, as amended by Chapter 466, Laws of 1901, the Commissioner of Charities is constituted an Overseer of the Poor, and as such has power to dispose of all unclaimed bodies; to administer public morgues; to deport to other states or counties dependents not having a residence in the counties constituting the City of New York; to collect from Overseers of the Poor of other counties for the care of dependents cared for in New York City but having residence elsewhere in the State. There is need for the exercise of these powers in Bellevue and its allied hospitals, since non-residents are received by these hospitals, and the lack of these powers involves the Bellevue hospitals in a heavy annual expense for the care of non-residents.

The Department of Public Charities is obliged, by the City Charter, to receive all patients which the Bellevue Department desires to transfer to it.

Friction has arisen over this provision, because of the fact that the Commissioner of Charities endeavored to build up an acute service in his Department, and, accordingly, attempted to reserve beds for the use of such cases. It became the practice to notify Bellevue each day of the number of cases that might be transferred, and the number of beds thus reported seldom was sufficient to accommodate the patients needing transfer. Accordingly, Bellevue adopted the practice in not a few instances of discharging patients to the street with the suggestion that they apply to the Department of Charities for admission. Should they make direct and personal appeal to the Department of Charities they could not be refused admission. Such practice was objectionable, but it seemed to the Bellevue authorities the only means of relieving themselves of chronic patients. The Commissioner of Charities no longer holds to this practice. Nevertheless, the possibility remains of some future Commissioner again resorting to the practice, much to the detriment of Bellevue.

The Charter is not clear as to the power of Bellevue to increase its facilities by the building of new hospitals. It is clear, however, as to such power on the part of the Department of Public Charities. Though the Bellevue Department has been assigned by inference certain territory, nevertheless, it apparently cannot meet the growing needs of the City by the erection of new institutions. The needs, it would seem, must be met by the Department of Public Charities invading the field assigned to the Bellevue Department.

At present there is no coöperation between the Departments of Health, Charities, and Bellevue and Allied Hospitals in the use or assignment of field nurses or social service workers. Nurses from the three Departments may, and do, visit the same neighborhoods, and perchance the same families. It might readily happen that three members of one family would simultaneously be in hospitals of the three Departments and a social service worker be sent from each hospital to the one home.

Each of the three Departments receives and cares for tuberculous patients without agreement as to the class of cases received by each. Since medical records are not exchanged by the three Departments much needless duplication of work results. The Department of Health maintains tuberculosis clinics throughout the City. Regardless of this fact, the Commissioner of Charities, in 1913, established in Brooklyn a tuberculosis clinic which in a large measure duplicated the work done by the Health Department. No consistent policy exists for the handling of the tuberculosis problem, and none seems likely to be established so long as three non-coöperating departments are adopting conflicting policies.

The Health Department is opening clinics for venereal diseases, although the Departments of Bellevue and Public Charities receive these cases into their hospitals. Whooping-cough cases are received by the Department of Public Charities, and also treated in clinics by the Department of Health. Though the Department of Health operates its hospitals presumably for contagious cases, nevertheless, all cases of leprosy are cared for at Metropolitan Hospital by the Department of Public Charities.

The number of cases received by a hospital, either private or public, is in a large measure dependent upon the size and character of its ambulance territory. The ambulance districts are determined and assigned by the Board of Ambulance Service, composed of five members, of whom three are *ex officio* the Commissioner of Charities, the President of the Board of Trustees of Bellevue and Allied Hospitals, and the Police Commissioner.

The remaining members are appointed by the Mayor. Though the City has adopted the policy of caring for all dependent and emergent cases in its municipal hospitals, nevertheless, the problem of assigning ambulance territory to the hospitals is in the hands of a board independent of the hospitals.

No consistent policy exists for the care and treatment of the sick. It is obvious that one should be adopted. Can it be brought about while they are received in hospitals operated by three independent and non-coöperating departments? This is a question which has often been asked. The Commission on Hospitals appointed by Mayor McClellan devoted much time in an attempt to answer it and finally made a recommendation that all hospitals be placed under the control of one department.

The problem is not easy of solution. There is no inherent reason why hospitals should not be administered by three departments, provided the departments coöperated. In the past, however, these Departments have not met on a common ground to discuss their problems and to agree upon policies. But this is not necessarily due to the fact that two of these Departments have been administered by Commissioners appointed by the Mayor, and the third by a Board of Trustees which is largely independent of the Mayor, for the two Departments headed by Commissioners have not coöperated, nor has the Department of Water Supply, Gas, and Electricity, which has certain powers over the physical plants of these Departments, coöperated with either. In the past the Mayor has not sought, or has not been able, to bring his Commissioners on to a common ground.[1] The proverbial jealousies of medical boards have some foundation in fact and must be reckoned with. Apparently some unified power is needed to force a consistent policy. It seems probable that such force must take the form of one head to all hospitals, with the possible exception of those caring for quarantinable cases.

Various forms of consolidation have been suggested. The most comprehensive is that every department of the City dealing with public health or public well-being shall be consolidated into one department. According to this suggestion, in such a department would be included all of the work now performed by the Departments of Health, Bellevue and Allied Hospitals, Public Charities, Public Recreation Commission, Board of Inebriety, and the Board of Ambulance Service. The functions performed by these various Departments, Commissions, and Boards overlap in quite a measure, and are correlated in many ways. Thus it would be logical to have all of these functions supervised by one head, and by such an arrangement many of the conflicts now existing in fields lacking definition between the Department of Health and the Departments administering hospitals would be obviated. It would also simplify some of the problems of the Fire Department and the Police Department. At the present time these two Departments pay for the services of physicians to care for their employees, and these physicians are required to go to various parts of the City to attend such employees while sick in their homes. By such a comprehensive plan as suggested above the district physicians of the proposed department could readily perform all the functions now performed by the physicians of the two Departments mentioned. The puzzling problem

[1] Mayor Mitchel is in quite a measure forcing coöperation, but the extent to which this policy may be carried is problematical, and, even though successful, may not be continued by a succeeding mayor.

of how far the Health Department shall go in the curative field would also be solved by a consolidation of the Departments.

Theoretically, a consolidation of all of these Departments is desirable. The practical difficulties, however, are great. The details to be handled in such a consolidated department probably would be as great as those of all the other Departments of the City combined, and the annual expenditures of this consolidated department would be, including the cost of public patients in private hospitals, fully $16,000,000.00. The head of such a Department would outrank all other Commissioners, and in order to secure a man competent to fill the position it would be necessary to pay a salary not materially less than that now received by the Mayor. The deputies to be associated with such a directing head should not be of less caliber than the Commissioners at the head of the existing Departments, and it probably would be difficult to secure men of standing to fill these subordinate positions.

Another suggestion is that the Department of Bellevue and Allied Hospitals be absorbed in the Department of Public Charities. This seems but a partial solution. The Board of Trustees of Bellevue and Allied Hospitals, though manifesting many shortcomings, nevertheless has greatly advanced hospital practice, while politics has been abolished from the Department and its services have improved accordingly. The Department of Public Charities has been stimulated by the example set by Bellevue. To absorb the Bellevue hospitals back into the Department of Public Charities would seem to be a backward step, and, moreover, were this done, the contagious disease hospitals, including especially part of those caring for tuberculosis, would still remain under the control of the Department of Health. A consistent policy of handling the tuberculosis problem would not result from such a readjustment.

It has been proposed that a department be formed to administer all hospitals, and that the Department of Public Charities retain the almshouses and the other problems now assigned to this Department. But the tendency of almshouses by necessity is to develop hospitals for cases of sickness, since a majority of almshouse inmates are ill. Hospitals first came into existence in this City in this way. It is highly probable that were almshouses alone to remain in the Department of Public Charities hospitals would gradually develop in connection with them. Therefore, to insure that all hospitals shall be, and continue to be, in one department the almshouses must be included with the hospitals in any scheme of consolidation.

Were a hospital department formed some would advocate that the hospitals for contagious cases remain in the Health Department. It would seem practicable to make this classification, provided the hospitals for contagious diseases received only quarantinable diseases, and all other contagions and infections, such as tuberculosis and venereal diseases, be assigned to a hospital department. However, while this classification or assignment would undoubtedly work, there seems to be no strong reason why the hospitals for contagious diseases should not be included with all other hospitals in one department. The Health Department has power to control the admission and discharge of contagious cases in whatever hospital, and it also has power to dictate the treatment and care of such cases. This power would safeguard its obligations and responsibilities. But were the contagion hospitals in a department with all other hospitals a better distribution of contagious cases might be effected.

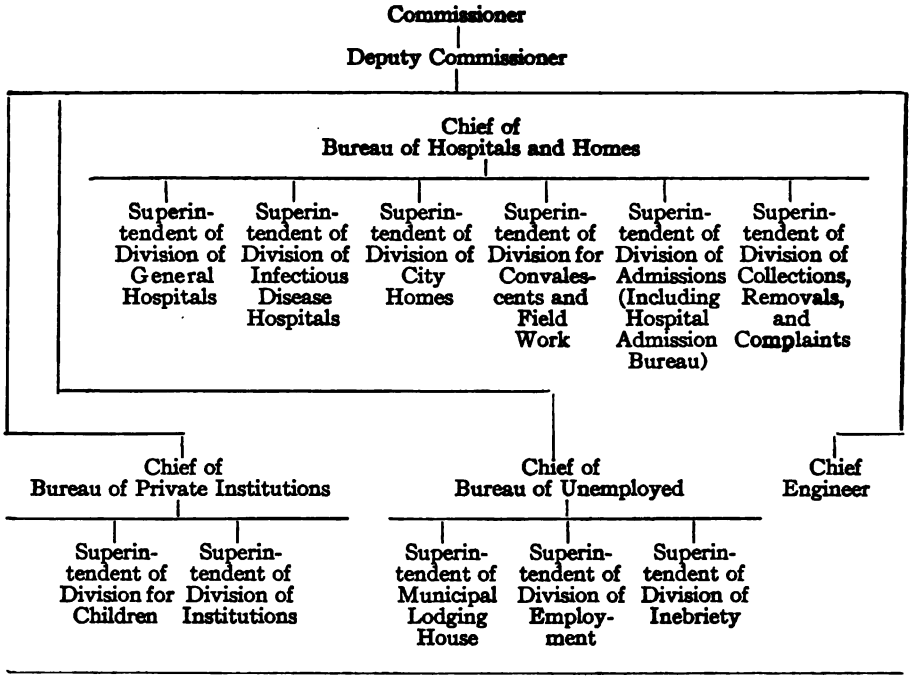
It does seem highly desirable to consolidate the Department of Bellevue and Allied Hospitals, the Department of Public Charities, the Board of Ambulance Service, the Board of Inebriety, and the Hospital Admission Bureau, and to omit from such consolidation that part of the work of the Department of Health not connected with hospitals.

A consolidated department should be presided over by a single head, and, doubtless, opinions would differ as to the method of selecting this head. The reasonably good record of the Bellevue Department would argue the advisability of providing a board of trustees, with power to appoint a commissioner and to formulate policies. Such a system in most regards would be desirable, for it would tend to eradicate politics from the department and would insure a competent commissioner. The chief value of a board of trustees would seem to be to maintain a consistent program and policy. On the other hand, trustees many times, though conscientious, are inclined to let one strong man in the board dominate, which domination tends to conflict with the administrative head; and such conflict results in scattered responsibility and inefficiency.

An appointee by the Mayor might be dominated by political affiliations and a change in policy might occur in each administration. These considerations must be carefully weighed. But somewhat counterbalancing them is the fact that a mayor is very sensitive to public criticism and would be inclined to hold his commissioners closely to the demands of the public. And, too, more rapid progress is likely to be made by a commissioner appointed by a mayor than one whose appointment is made by a board of trustees. All things considered, it seems advisable to provide that the proposed consolidated department be headed by a Commissioner appointed, as are other commissioners, by the Mayor. To secure continuity of service and an assurance of competence it might be well to provide that the Mayor appoint only the Commissioner and a Deputy, and that all other heads be Civil Service appointees.

The proposed department should have a number of bureaus, each headed by a Chief. The following bureaus are suggested: 1, Hospitals and Homes; 2, Private Institutions; 3, The Unemployed; 4, Engineering.

This organization may be charted as follows:



Suggested Salaries

Commissioner	$10,000
Deputy Commissioner	7,500
Chief of Bureau of Hospitals and Homes	6,000
Chief of Bureau of Private Institutions	5,000
Chief of Bureau of Unemployed	5,000
Chief Engineer	5,000
Superintendent of the Division of General Hospitals	4,000
Superintendent of the Division of Infectious Disease Hospitals	4,000
Superintendent of the Division of City Homes	3,500
Superintendent of the Division of Convalescents and Field Work	3,500
Superintendent of the Division of Admissions	3,500
Superintendent of the Division of Collections, Removals, and Complaints	3,500
	$60,500

Included in the above list are three positions recommended in other sections of the Report of this Committee as being necessary for the adequate handling of the problems in connection with the Department of Bellevue and Allied Hospitals and the Department of Public Charities. These positions are: a Superintendent in charge of the problem of convalescents; a Superintendent of a division for collections and removals; and a Superintendent of City Homes. The aggregate salaries of these is $10,500. The salaries of the officers at present performing all of the functions indicated by the above list, with the exception of the new positions, aggregate $54,700.

The present positions, with the salaries indicated, are as follows:

Commissioner		$7,500
Three Deputies		15,000
General Medical Superintendent, Department of Public Charities		6,000
Chief Engineer		4,500
General Inspector		3,000
Superintendent, Bureau of Dependent Adults		2,700
Director, Board of Ambulance Service		5,000
Bellevue Administration, present cost	$12,000	
Cost of positions to be retained	7,000	
Net present cost		5,000
Superintendent, Contagious Disease Hospitals		3,000
Secretary, Board of Inebriety		3,000
		$54,700

Since the total proposed expenditure for the salaries of administrative officers for the suggested consolidated department is $60,500, and the amount at present expended for these functions is $54,700, the proposed department shows an increased expenditure of but $5,800, with three new positions included among the officers of the proposed department.

The duties of the officers of this proposed department may be described as follows:

The Commissioner and Deputy Commissioner, to be appointed by the Mayor, would have entire charge of the department as administrative officers, performing functions common to such heads. By having one commissioner in charge of the various bureaus indicated, the conflicts and maladjustments heretofore noted as at present existing between departments should be obviated. All of the sick and dependent of the City would be cared for by this department. One commissioner, having charge of the entire problem, would be able to make such classification of hospitals and bureaus as would most adequately perform the functions now inadequately performed because of their distribution among several departments. The tuberculosis problem would be handled as a whole by this department, with the possible exception of the field clinics operated by the Health Department, if these be omitted. Likewise, the problem connected with the care and treatment of venereal diseases would be consistently handled. The distribution of chronic cases would be subject to the control of the Commissioner, and the character of the cases to be treated in each hospital would be prescribed by him. He would be enabled to provide better training for internes and nurses by assigning them for stated periods to specialized hospitals.

The immediate administration of the various problems of the department would be in the hands of Chiefs whose tenure of office would be made secure by Civil Service regulation. All the hospitals and homes would be grouped together in one division, inasmuch as they involve similar problems of administration, especially in the care of the physical plant, the purchasing of supplies, and the feeding of patients and inmates.

All the problems in connection with the care of City patients in private institutions and the placing out of children would be under the supervision of one Chief.

The problem of the unemployed would be under another Chief. He would have supervision of the Municipal Lodging House and all employment bureaus which the City may see fit to operate, and such other problems as might arise in connection with the unemployed. He would also supervise the Farm for Inebriates.

The Chief Engineer would be in charge of all the engineering problems of the proposed department.

The hospitals, according to the plan, would be divided into two groups; namely, general hospitals and infectious hospitals, with a Superintendent in charge of each group.

The City Homes (almshouses) would constitute another group, in charge of a Superintendent. This is a new office and is required by the many problems which have not been adequately handled heretofore in connection with the almshouses. The employment and care of inmates of these Homes have not received the attention that they should have received.

Another innovation proposed in the plan is that of a Division for Convalescents and Field Work, in charge of a Superintendent. Up to the present time the City has made almost no provision for the care of convalescing patients in their homes, or institutions other than the hospitals. Marked economies could probably be secured by providing convalescent homes and by caring for convalescing patients in their own homes. This officer would also have charge of the work in connection with the Health Centers proposed by the Committee.

Admissions to the Homes, which are now provided for by the Bureau of Dependent Adults, would be in charge of the Superintendent of a division performing similar functions. This officer would also supervise the Hospital Admission Bureau for the admission of tuberculous patients.

Another of the new officers proposed is a Superintendent of a Division for Collections, Removals, and Complaints. As set forth in the report of this Committee under the subject of Aliens, Non-Residents, and State Poor in City Institutions, the City is at great expense at the present time in caring for non-residents and dependent aliens, and a large amount of money could be saved by having such matters in charge of a competent officer to make collections where possible and to remove when found advisable. This officer would also handle all complaints.

It is believed by the Committee that the proposed department suggested is advisable, feasible, and would result in much greater efficiency in the care and treatment of the sick and dependent, and would also result in marked economy, and the Committee recommends that legislation be enacted providing for its creation and installation.

It is difficult to select a name for such a consolidated department. The name "Public Welfare Department" would be very appropriate were the Department of Health included in the consolidation, but without the inclusion of this Department the term is rather too broad in scope. The term "Public Care and Welfare" would be a somewhat more restricted title, and would describe fully the work to be carried on in the proposed department. The name, "Welfare Department," or, "Social Welfare Department," would also be appropriate.

Should the consolidation be brought about it would not render needless the reorganization of Bellevue Hospital suggested in Part I of this Section. The only necessary change in the plan as proposed would be the substitution of the word Commissioner for Board of Trustees.

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